10-3-1984

Health Insurance: Overlapping Jurisdiction between the Departments of Corporations and Insurance

Assembly Committee on Finance and Insurance

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

October 3, 1984

INTERIM HEARING

HEALTH INSURANCE: Overlapping Jurisdiction between the Departments of Corporations and Insurance

COMMITTEE STAFF REPORT

9:30 a.m. to 4:30 p.m.
Room 4202 — State Capitol
Sacramento, California

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California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
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November 5, 1986

MEMORANDUM

TO: Chairman McAlister and Members of the Assembly Finance and Insurance Committee

FROM: Sal Bianco, Principal Consultant

SUBJECT: COMMITTEE STAFF REPORT

In lieu of conducting an interim hearing on the overlapping jurisdiction of health insurance by the Departments of Corporations an Insurance, a COMMITTEE STAFF REPORT has been prepared. The Departments have submitted separate written responses to a series of thirty questions relating to policy issues in concurrent health coverage regulatory activities.

SB:ely

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

September 19, 1984

MEMORANDUM

TO: Members, Finance and Insurance Committee

FROM: Sal Bianco, Principal Consultant

SUBJECT: October 3 Interim Hearing

As you are aware, our Committee had scheduled an October 3 interim hearing on the subject of overlapping jurisdiction by the Departments of Insurance and Corporations in the area of health insurance. As of this date, the October 3 hearing has been postponed.

Chairman McAlister will be meeting with the Commissioners of Insurance and Corporations in mid-October to discuss further this overlapping jurisdiction problem. Those parties which have expressed an interest in testifying at the October 3 hearing have been notified that they may submit their written comments to us by the end of October. Upon review of the Departments' written response on this subject matter, the results of the mid-October meeting, and comments by interested parties, a determination will be made at the end of October whether a future public hearing on this subject matter should be scheduled.

I will be happy to provide you a more detailed briefing. Please feel free to contact me at (916) 445-9160.

SB:ws

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

September 19, 1984

MEMORANDUM

TO: Interested Parties

FROM: Sal Bianco, Principal Consultant Sal

SUBJECT: October 3 Interim Hearing

Thank you for expressing interest in our Committee's interim hearing set for October 3 on the subject of overlapping jurisdiction by the Departments of Insurance and Corporations in health insurance.

We have postponed this hearing.

Chairman McAlister, along with Senator Robbins, will be meeting privately with the Commissioners and their staffs on October 15 to discuss the subject matter. Upon review of their responses and response to additional questions which may arise at the October 15 meeting, we will make a determination at the end of October whether to proceed further and schedule a public hearing. In the meantime, however, we invite your organization to submit to us by October 30 your written comments on this subject matter.

Should you have any questions, please feel free to contact meat (916) 445-9160.

SB:ws

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

September 19, 1984

Mr. Bruce Bunner
Commissioner of Insurance
100 Van Ness Avenue, 17th Floor
San Francisco, California 94102

Mr. Franklin Tom
Commissioner of Corporations
1025 P Street, Room 205
Sacramento, California 95814

Dear Bruce and Franklin:

As you are aware, our Assembly Finance and Insurance Committee had scheduled an October 3, 1984, interim hearing on the subject of overlapping jurisdiction by your Departments in the area of health insurance. Additionally, as Dave Ackerman has informed you, we have postponed that hearing and invite both of you to attend a meeting with Chairman McAlister, Senator Robbins, and legislative staff on Monday, October 15, 1984, at 10:00 a.m. in Mr. McAlister's office, Room 3112 in the State Capitol.

On behalf of Chairman McAlister, I personally invite you to this meeting along with Department staff you wish to bring to address the subject matter of overlapping jurisdiction by your Department in the area of health insurance. You will receive shortly a series of questions we want you to address in writing at the October 15 meeting. We will consider as public the written responses you provide with substantiating documentation. Since a number of questions will be detailed, and additional questions may be raised at the October 15 meeting, we will need to be in receipt of all written responses no later than October 30. After the October 15 meeting and review of your responses, we will determine whether an interim hearing needs to be conducted.

For your information, interested parties who have indicated that they wished to testify at the October 3 hearing, will be notified of our actions and will be invited to submit their written comments to us by October 30.

We appreciate your past efforts of mutual communication on this subject matter and your continued efforts. We look forward to seeing you on October 15 at 10:00 a.m.

Thank you for your consideration in this matter. As always, please feel free to contact me at (916) 445-9160.

Sincerely yours,

SAL BIANCO
Principal Consultant

SB:ws
cc: Assemblyman Alister McAlister
Senator Alan Robbins
Mr. Shel Davidow
Mr. Dave Ackerman
Mr. Brian Walkup
Mr. Bill Kenefick

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
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(916) 445-9160

December 13, 1984

Mr. Bruce Bunner
Commissioner
Department of Insurance
State of California
600 South Commonwealth Avenue, 14th Floor
Los Angeles, CA 90005

Mr. Franklin Tom
Commissioner
Department of Corporations
State of California
600 South Commonwealth Avenue
Los Angeles, CA 90005

Dear Bruce and Franklin:

As you recall, we met in my office on October 15, 1984, along with Legislative, Agency and Department staff to discuss the issue of overlapping jurisdiction between your departments in the area of health coverage. Specifically, we discussed my consultant's October 4, 1984, letter prepared on behalf of the Committee and addressed to you setting forth 30 questions and requesting your written response by October 30.

During our meeting we discussed a number of questions. At the meeting, neither of your departments provided any information to us in writing. I specifically requested that your departments submit written responses to me on each of the 30 questions set forth in the October 4th letter and I was willing to provide you some additional time to do so. As of this date we have received no written response.

We intend to publish a Committee Staff Report regarding this interim hearing subject matter. Recognizing your expressed willingness to be responsive to our inquiries and affording you

the continued opportunity to respond to our Committee's request, I have extended the deadline for receiving your separate written responses until January 30, 1985. At that time we will proceed to publish our Committee Report on this interim subject matter. We expect it to be available in early Spring and to be utilized during the 1985-86 Legislative Session as further background on policy and fiscal issues we will be considering.

I recognize that a number of the 30 questions may be too detailed, too complex, or require future department experience thereby resulting in difficulty for you to answer specifically. Should any questions meet these difficulties, you should so indicate in your written response and the reasons which lead you to your conclusion. I want to indicate once again that you should provide documentation as part of your answer when any question requires submission of further background information.

Thank you for your attention to my current request. Should you have any questions or need for additional assistance, please feel free to contact Sal Bianco, Principal Consultant to my Committee at 5-9160.

Sincerely yours,

ALISTER McALISTER
Chairman

AM:kt

cc: Senator Alan Robbins
Sal Bianco ✓
Sheldon Davidow, Senate Insurance, Claims & Corporations
David Akerman, Deputy Secretary, BT&H Agency
Roxani Gillespie, Chief Deputy, Department of Insurance
Richard Camilli, Assistant Corporations Commissioner, Knox-Keene Health Care Service Plan Program
Brian Walkup, Department of Insurance
Bill Kenefick, Department of Corporations
Mike Reyna, Program Analyst, Legislative Analyst
Mary Jane Jogadzinski, Consultant, Assembly Ways & Means
Steve Thompson, Chief of Staff, Assembly Speaker's Office
Jim Cathcart, Consultant, Senate Ins., Claims & Corps.
Joanne Steiner, Consultant, Senate Finance Committee
Simon Haines, Sr., Consultant, Senate President Pro Tem

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

February 11, 1985

Mr. David Ackerman
Deputy Secretary
Business, Transportation
and Housing Agency
1120 N Street
Sacramento, California 95814

Dear Dave:

As you recall, we have had one meeting and have sent two letters dated October 4, 1984, and December 13, 1984, on the issue of overlapping jurisdiction between the Departments of Insurance and Corporations in the area of health coverage. Additionally, Sal Bianco, Principal Consultant to my Committee, has informed me of a discussion he has had with you, Franklin, and Bruce regarding your response to our inquiry.

As we see the situation, both Bruce and Franklin are sincere and willing to respond to the 30 questions set forth in our October 15, 1984, correspondence.

Their concern, which you share, is that in order to answer each question fully, a significant amount of Department personnel time and the gathering of substantiating documents will be needed. Additionally, the Departments may submit too much documentation on some questions and too little on others either because of their misunderstanding of what the question requires for a response or the lack of existing documentation. Further, both Bruce and Franklin, with your agreement, offered to set aside specific time for Sal to travel to their offices, meet with them separately; with their staff; and, review and request further documents on any of these 30 questions.

Based on the above, we understand your reasons for being unable to meet our deadline of January 30, 1985, to respond to each of these questions. However, we intend to publish a COMMITTEE STAFF REPORT regarding this interim hearing subject matter.

In our view, the issue of overlapping jurisdiction in the area of health is as important as the overlapping jurisdiction regarding financial institution transactions. With the protection of the public the utmost goal shared by all of us, over-response to any of the 30 questions is productive and beneficial. As to the point of under-preparing a response, we recognized this possibility in our December 13 correspondence to both Bruce and Franklin when we indicated that should any questions meet difficulties which we outlined in our letter, the Department should explain in their written response and reasons which led them to their conclusion.

To assist you we have divided the 30 questions into two categories. Category I contains those questions requiring a response without the initial need for substantiating documentation; and, Category II contains those questions requiring a response with initial documentation. The following questions are in Category I: 1, 6, 9, 11, 18 - 22, 24, and 28 - 30. The remaining questions are Category II.

Your Departments have had these questions in their possession since mid-October, 1984. Our October 15 meeting in my Capitol Office afforded a discussion on each of these questions. We are aware that Department personnel have devoted time in preparing responses. As a result, we will extend the deadline for receiving the Departments' separate written response to each of the 30 questions to 30 days from the date of this letter.

You should be aware that our target date to publish the COMMITTEE STAFF REPORT will be March 30, 1985. This date will still allow ample opportunity for both policy and fiscal committees to consider any of the surrounding issues, but, most importantly, allow each of your Departments ample opportunity to provide any additional information or clarification.

I appreciate your willingness and the willingness of Bruce and Franklin to be responsive and to devote their personal time and effort on this important matter. We intend to visit with the Commissioners and their staffs in Los Angeles later this year. We will give you as much advance notice as possible regarding any future visits.

Thank you for your attention to my request. Should you have any questions or a need for additional assistance, as always please feel free to contact me directly at 5-7874 or to contact Sal at 5-9160.

Sincerely yours,

ALISTER McALISTER

AM:ws

cc: Mr. Kirk West, Secretary, BT&H Agency
Mr. Franklin Tom, Corporations Commissioner
Mr. Bruce Bunner, Insurance Commissioner
Assembly Member Maxine Waters
Senator Alan Robbins
Sal Bianco
Sheldon Davidow, Senate Insurance, Claims & Corps. Committee
Roxani Gillespie, Chief Deputy, Dept. of Insurance
Richard Camilli, Assistant Corporations Commissioner, Knox-Keene Health Care Service Plan Program
Brian Walkup, Department of Insurance
Bill Kenefick, Department of Corporations
Mike Reyna, Legislative Analyst's Office
Constance Miller, Assembly Ways & Means Committee
Steve Thompson, Chief of Staff, Assembly Speaker's Office
Jim Cathcart, Senate Insurance, Claims & Corps. Committee
Joanne Steiner, Senate Finance Committee
Simon Haines, Consultant, Senate President Pro Tem

California Legislature

Assembly Committee on Finance and Insurance

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

October 4, 1984

Mr. Bruce Bunner, Commissioner
Department of Insurance
100 Van Ness Avenue, 17th Floor
San Francisco, California 94102

Mr. Franklin Tom, Commissioner
Department of Corporations
1025 P Street, Room 205
Sacramento, California 95814

Dear Bruce and Franklin:

As indicated in our September 19 letter to you, we are providing a series of policy issue questions on the subject of overlapping jurisdiction by your departments in the area of health coverage. We invite your separately written response to each question with substantiating documentation. These policy questions are the agenda items for our October 15 meeting beginning at 10:00 a.m. in Assemblyman McAlister's Capitol Office. We look forward to any additional items you may wish to add to the meeting agenda for discussion. We realize you want to comment extensively in writing on some or all of the questions either prior to, at, or after the October 15 meeting. We invite you to do so.

Because of the depth and complexity of your departments' overlapping activities, these policy issue questions appear to require extensive and significant dialogue. After addressing the policy issue questions, we will provide you with a series of questions relating to the revenue and operating cost aspects of your departments prior to October 15. These revenue/operating cost issue questions along with any questions raised at the October 15th meeting can be responded by you in writing with substantiating documentation by October 30th.

Please feel free to contact me directly if I can be of further assistance to you. The following series of questions are numbered for your easy response and indexation.

1. It has been contended and publicly acknowledged that there are areas of overlapping jurisdiction in the health field by your departments. In your own view, what areas do you believe overlap and what brings you to these conclusions?

2. Relating to question number 1, what would you modify administratively to eliminate these overlapping areas? Absent administrative action, what statutory language would you propose to allow you to eliminate the overlap?

3. What procedures do you currently use to consult with each other on persons, licensees or entities where overlapping jurisdiction exists? To what degree do you work with the Department of Health Care Services or any other State agency? Do you have a formal written policy and are there established scheduled periodic meetings with the required liaison?

4. AB 1166 (McAlister - Chapter 1006, Stats. 1984) will take effect January 1, 1985. How do you intend to implement this measure? Will you establish a written policy and procedure? What role (duties/responsibilities) do you or an individual assigned by you plan to initiate in implementing this measure? Do you foresee the need to expand your consultation with other state agencies?

5. In your view, what responsibility does your department have in ensuring a level of health care quality and service? How do you administer that responsibility? What level of health care quality and service have you established as the criteria to measure licensee performance?

6. How do you integrate the financial solvency and level of service factors in the regulation of persons, licensees and entities under your jurisdiction? Do you have regularly scheduled periodic audits for financial solvency? Do you have regularly scheduled periodic audits for health care quality and service? If you perform both, are they separate or are they an integrated audit? Please explain why you have adopted one policy procedure over another.

7. In the area of licensing, what tests (objective standards) do you apply to your licensees? Please identify those factors (tests) for maintaining a license and for obtaining a license.

8. What disclosure requirements do you current apply on the products offered to the general public by your licensees? What additional disclosure requirement do you feel should be added by either administrative regulation and/or by statute, and why? Should there be established a common set of disclosure requirements to be applied to your licensees?

9. What role do you see for your department in addressing the claim of federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA) by persons or health entities claiming lack of state jurisdiction by your department? Have your attorneys researched and provided you a formal written opinion on whether or not persons or entities, which claim your agency lacks jurisdiction due to ERISA, are correct or incorrect in their claim? If so, what have been their conclusions and have you used these opinions as the basis for departmental policy?

10. AB 3342 (McAlister - Chapter 640, Stats. 1984) took immediate effect on August 16, 1984. How have you implemented this measure? What written procedures and policies have you established? What additional duties or responsibilities have you undertaken to yourself or a specified individual in implementing this measure? Have you used the provisions of AB 3342 in an investigative or enforcement action since its enactment?

11. Regarding the "coordination of health insurance benefits" issue, how do you view AB 3342 provisions in assisting your department with its enforcement actions? In particular, what role has or will your department play in assisting persons, licensees and entities under your jurisdiction to assure coordination of benefit payments in the "Valley Clerk's Trust Fund" case located in San Joaquin County? Additionally, what steps has your department taken to implement the provisions of SB 2024 (Maddy - Chapter 1066, Stats. 1982)?

12. As you know, Insurance Code Section 740 was added by AB 2670 (McAlister, Chapter 706, Stats. 1982). SB 952 (Robbins, Chapter 277, Stats. 1983) strengthen this section and required licensure under specified conditions. These measures

deal with presumed jurisdiction to the Department of Insurance over multiple employer trust (METs) unless the entity or person is regulated under the Knox-Keene Health Plan Act of 1975. Since these measures took effect in September 1982 and in 1983, what changes in statutory language, if any, has your department proposed as the result of implementing these measures?

13. Relating to question 12, since the enactment of AB 2670, how have you implemented this measure? What written procedures and policies have you established to address the overlapping jurisdiction by your Departments? How have you integrated your consumer complaint, enforcement, investigations, financial analysis, and legal activities in your Department in implementing AB 2670?

14. Relating to question 12, how does your department define the following terms used in Insurance Code Section 740: "entity," "services," "coverage," and "regulated?" If the statute language was changed from "providing coverage in this state" to "providing services in this state" how would your interpretation and definition change?

15. In the past we have asked your Department to provide us with results of enforcement actions under Insurance Code §740. From the enactment date of AB 2670 and SB 952, please provide a list of all formal investigative and enforcement actions undertaken by your Department pursuant to Insurance Code §740. For formal actions, please specify the person or entity and the results of your actions. What number of investigating actions are currently underway and what is their status? In your view, what proposed modifications do you suggest to Insurance Code §740 and any other Code section which have statutorily prevented you from more effective enforcement? Are you prevented from taking more effective enforcement action because there are operative sections in both the Health and Safety and Insurance Codes?

16. The provisions of AB 2347 (McAlister - Chapter 947, Stats. 1984), which took effect August 27, 1984, and AB 3342, which took effect August 15, 1984, address the overlapping jurisdiction issue. Specifically, language in added Insurance Code §742 and amendments to Insurance Code §1759 provide for "subject to regulation" for any person or entity under the Knox-Keene Health Plan Act of 1975. As you are aware, when Insurance Code 740 was enacted, the word "regulated" was used. Section 740

language has been changed to "subject to regulation." In your view, do you find any difference in your interpretation of the word "regulated" with the new language of "subject to regulation?" If yes, why? If no, why not? Do you believe a licensee, person or entity could be subject to both of your Departments' jurisdiction at the same time? If yes, what written policies or procedures have you adopted to address this concurrent jurisdiction?

17. AB 2347 provisions add Insurance Code §742 and contain the term "preferred provider organization" (PPO). In your view, how do you define this term and how have you implemented this newly added Insurance Code section? Have you used the provisions of AB 2347 in an investigative action, interpretative opinion request, or enforcement action since its enactment?

18. AB 707 (Isenberg) was passed by the Legislature, but vetoed by the Governor. The Department of Corporations opposed the measure; the Department of Insurance took no position. In your view, how do you interpret the provisions of AB 707, which provides legislative intent that alternative rate contracts between purchasers or payors of health care services and institutional and out-patient providers are exempt from state and federal antitrust provisions? How do its provisions affect your licensees?

19. Relating to question 18, it has been contended by the California Attorney General's Office that absent regulation, PPO's are not exempt but subject to state antitrust provisions. It has also been contended that the U.S. Department of Justice and the Federal Trade Commission view a "pro-competitive" PPO as exempt from federal antitrust provisions. Based upon these two contentions, in your view does the absence of specific regulation by either of your Departments with respect to PPO's require immediate administrative and/or statutory designation of the regulator? Further, in the absence of a specific PPO regulator has a barrier to reducing health care costs been created?

20. In your previous written responses to us on the Legislative Counsel's opinion on preferred provider organizations, there has been some discussion raised over whether you have jurisdiction. Given the fact that you may have jurisdiction, what do you believe would be the appropriate level of regulation? Should there be a full regulatory program?

Should there be a limited program to require adhering to administratively adopted standards of conduct after public hearings are conducted? Or, do you believe preferred provider organizations should be subject to a registration only program requirement? In what state agency should this registration occur? What role should your Department and the Department of Health Care Services and the Office of the Attorney General play in any type of regulatory program?

21. Today, in the marketplace we find a nonprofit hospital service plan or insurance company creating a health maintenance organization or health care service plan. This results in separate but overlapping jurisdiction by your Departments. In your view, should there be a common formal procedure for monitoring these licensees by your Departments? If yes, how would you implement such a proposal?

22. During the 1983-84 Legislative Session, numerous bills dealing with mandated health coverage were amended to exempt specific licensees, such as health maintenance organizations, from their provisions. In your view, should organizations, such as Kaiser, Blue Shield, and Blue Cross, be exempted from these bills' provisions?

23. In the area of complaints from the general public as it relates to health coverage, please provide specific data on the number of complaints and the complaint subject matter referred by the Department of Insurance to the Department of Corporations and vice versa based on grounds of jurisdiction. Regarding medical malpractice insurance coverage by providers, what role do you believe you have in determining this issue? In your view, do you believe there should be a formal procedure for handling consumer complaints where overlapping jurisdiction exists?

24. Within your own Department, how do you integrate your enforcement, and legal activities with the receipt of consumer complaints relating to health coverage? Do you involve your licensing and financial audit activities?

25. In your view, what jurisdiction authority do you have over administrators, medical care foundations, solicitors, solicitor firms, and exclusive provider organizations? Please provide a list of the factors used in defining each of these entities.

26. The Department of Insurance's August 22 correspondence raised the possibility that PPO's might engage in certain activities bringing them within the Department's jurisdiction over insurance administrators. In view of this possibility, what has your Department undertaken to develop internal written procedures and policies to alert your Department personnel to watch for specified activities? What has the Department undertaken to publicly inform its licensees, in particular administrators, of the potentiality of their actions? What steps do you propose administratively or legislatively to address this potentiality?

27. The Department of Corporations is in receipt of the Department of Insurance's August 22 correspondence. Further, pursuant to AB 160 (McAlister, Chapter 830, Stats. 1983) provisions, the Department of Corporations has communicated to solicitors and solicitor firms. In view of these developments, what is the Department of Corporations' view on the possibility that PPO activities may cause them to be within the Department's jurisdiction over activities of solicitor and solicitor firms? Has the Department of Corporations undertaken any administrative action or issued interpretative formal opinions, etc. to inform its licensees of the potentiality of their actions?

28. Your Departments have indicated an informal development of information on PPO's procedure exists. What is your Department's assessment of PPO growth, potentiality for unfunded risk, etc., based on your information gathered? What is the status of your formal process to exchange information?

29. Some health care service plans have a substantial indemnity component in their operation, either as a basic part of their activities or to provide for out-of-area coverage or coverage for services which a health care service plan does not want to provide for itself. For example, Blue Shield has a substantial indemnity component in their operation. Kaiser Foundation Health Plan provides dental benefits strictly on an indemnity basis. Insurers and nonprofit hospital service plans are purchasing health care service plans. Some health care service plans have purchased insurers. In view of these developments, what is your view of establishing a formal common monitoring procedure and applying identical objective standards over these licensees? What leads you to your conclusion?

30. In your view, if you have concluded you do not want to transfer your jurisdiction in whole or in part to the opposing Department or any other state agency, what benefit(s) do you believe that you provide to your licensees and to the public which cannot be provided in whole or in part by another state agency?

Thank you for your attention to these questions.

Sincerely yours,

SAL BIANCO
Principal Consultant

SB:ws
cc: Assemblyman Alister McAlister
Senator Alan Robbins,
Mr. Shel Davidow
Mr. Dave Ackerman
Mr. Brian Walkup
Mr. Bill Kenefick

BCC: Mike Reynau, Legislative Analyst
Mary Jane Jagodzinski, Assembly Ways and Means Committee
Steve Thompson, Chief of Staff, Assembly Speaker's Office
Jim Cathcart, Sr. Consultant, Senate ICC Committee
Joanne Steiner, Senate Finance Committee
Simon Haines, Sr. Consultant, Senate President Pro-Tempore

1120 N Street
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GEORGE DEUKMEJIAN
GOVERNOR OF
CALIFORNIA

Alcoholic Beverage Control
Banking
Corporations
California Highway Patrol
California Housing Finance Agency
Commerce

Insurance
Housing and Community Development
Motor Vehicles
Real Estate
Savings and Loan
Transportation
Teale Data Center
Office of Traffic Safety

BUSINESS, TRANSPORTATION AND HOUSING AGENCY

March 14, 1985

The Honorable Alister McAlister
Chairman, Assembly Committee
on Finance & Insurance
State Capitol Building
Sacramento, CA 95814

Dear Assemblyman McAlister:

In response to your letter of February 11, 1985, I am pleased to provide independent responses from the Departments of Insurance and Corporations relative to the regulation of health coverage. The Departments have attempted to be as complete as possible in their answers and are available to you and your staff for more indepth discussion.

If you need assistance in coordinating further inquiries with the Departments, please do not hesitate to contact me. I appreciate your patience with us concerning this matter.

Sincerely,

DAVID G. ACKERMAN
Deputy Secretary

Enclosures

cc: Kirk West, Secretary
Bus., Transp. & Housing Agency
Franklin Tom, Commissioner
Department of Corporations
Bruce Bunner, Commissioner
Department of Insurance
Senator Robbins

STATE OF CALIFORNIA GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF INSURANCE
100 VAN NESS AVENUE
SAN FRANCISCO, CALIFORNIA 94102

March 12, 1985

The Honorable Alister McAlister
Chairman, Assembly Committee on Finance and Insurance
State Capitol Building
Sacramento, CA 95814

Dear Assemblyman McAlister:

This is my response to Sal Bianco's letter to Commissioner Tom and me of October 4, 1984, concerning our Departments' regulation of entities which provide or fund health care. Your letter of December 13, 1984, indicates that a specific request for complete answers to Mr. Bianco's questions was made in our meeting with you on October 15, 1984. However, I recall that we agreed instead that a series of meetings and exchanges of correspondence would be scheduled to focus on specific subject areas. I believe that the latter approach would do more to foster cooperation between our Departments and would provide your Committee and its staff with a more complete and balanced appreciation of our Departments' activities. Indeed, I found our meeting of October 15 to be quite useful.

Mr. Bianco's questions and my responses follow. "Tab number" refers to items in the Appendix enclosed with this letter.

> "1. It has been contended and publicly acknowledged that there are areas of overlapping jurisdiction in the health field by your departments. In your own view, what areas do you believe overlap and what brings you to these conclusions?"

RESPONSE: I believe that the "overlapping jurisdiction" cited by Mr. Bianco is more apparent than real. It is true that different functions of the same organization may be subject to regulation by my Department or by the Department of Corporations. For example, a holding company may own both an insurer and a Knox-Keene plan. However, there is no "overlap" in these instances -- rather, the jurisdiction of our Departments is parallel or "side-by-side". The operating methods of insurers and Knox-Keene plans (or HMOs) are inherently so different that separate units are usually necessary regardless of whether they are regulated by the same

or different state agencies. For example, when Blue Cross chose to establish Federally-qualified HMOs, subsidiary entities were established and licensed under the Insurance Code, even though that Code permits Blue Cross to provide HMO-type services itself. These HMOs appear to operate with considerable independence from Blue Cross even though they are wholly-owned by Blue Cross's holding company.

This parallel regulation may well be superior to that provided by one Department alone, since the separate schemes of regulation are more appropriate to the particular activities. In general, the Insurance Code provides comprehensive regulation of the financial activities of an entity with a view toward ensuring that entity's solvency, while establishing only a basic framework of standards in the area of sevice to insureds. Knox-Keene, on the other hand, concentrates more on "service" issues while providing relatively simple standards for financial matters.

There may be some jurisdictional overlap where unlicensed entities contain elements of indemnity and pre-paid service. There have been instances of unlicensed METs which appeared to come within both the Insurance Code and Knox-Keene, and which have been pursued by both Departments. Where unlicensed entities threaten the public welfare, it may well be that "two heads are better than one".

Splits and "overlaps" in jurisdiction over health care benefits are not limited to our two Departments. The rapidly increasing number of self-funded employer and union health plans are regulated solely by the U.S. Department of Labor, while quality of service issues are often the responsibility of state facility and professional licensing agencies or boards, regardless of how such services are funded. Although the split of jurisdiction between DOI and DOC may be confusing initially to persons unfamiliar with California regulation, few practical problems have resulted from it insofar as properly licensed entities are concerned. About the only "overlap" in this regard involves properly licensed administrators which may operate simultaneously in behalf of Knox-Keene plans, insurers and legally self-insured employer or union programs. Some of these administrators have complained of being visited by investigators from DOI, DOC and the Department of Labor, all of whom were working under different sets of laws. Increased liaison among these agencies has helped to resolve this type of problem.

"2. Relating to question number 1, what would you modify administratively to eliminate these overlapping areas? Absent administrative action, what statutory language would you propose to allow you to eliminate the overlap?

"3. What procedures do you currently use to consult with each other on persons, licensees or entities where overlapping jurisdiction exists? To what degree do you work with the Department of Health Care Services or any other State agency? Do you have a formal written policy and are there established scheduled periodic meetings with the required liaison?"

RESPONSE: I believe that my Department is currently taking all reasonable administrative steps to reduce the impact of any overlapping jurisdiction with DOC. My Department has long maintained informal liaison with DOC at the investigatory level, and our Departments have conducted a number of joint investigations of entities whose appropriate licensing status was in doubt. Most of our Departments' enforcement activities relative to unlicensed entities occur in southern California. Our offices in that part of the state are on adjacent floors of a smallish high-rise, so that regular contact between DOI and DOC enforcement personnel is easy and frequent. These contacts are close enough that investigators sometimes transfer from one Department to the other.

With the advent of PPO legislation, liaison between our Departments was tightened and, commencing in November, 1984, our Chief Investigators have scheduled formal quarterly meetings to exchange information and coordinate activities. These meetings have included discussions of existing cases, new leads, developments in the law and allocation of resources.

I have no statutory language to propose to "eliminate the overlap" because this "overlap", to the extent that it exists, may well give our Departments additional tools to deal with unlicensed entities.

As the Insurance Code gives DOI no authority over the quality of health care services rendered by facilities or practitioners operating in conjunction with our licensees, we have little occasion to work with the Department of Health Care Services.

"4. AB 1166 (McAlister - Chapter 1006, Stats. 1984) will take effect January 1, 1985. How do you intend to implement this measure? Will you establish a written policy and procedure? What role (duties/responsibilities) do you or an individual assigned by you plan to initiate in implementing this measure? Do you foresee the need to expand your consultation with other state agencies?"

RESPONSE: My Department regards AB 1166 as self-executing without requiring that any specific policy or guidelines be established other than following the statute's directive. The differing regulatory schemes of Knox-Keene and the Insurance Code and the widely disparate grants of authority to make

regulations under each mean that there are relatively few areas where parallel requirements apply to insurers and health care service plans. Also, the Legislature has begun to direct specifically that one Department promulgate regulations similar to those of the other when it feels that uniformity is necessary. DOI's regulations pertaining to exclusive provider arrangements are required to follow specified regulations adopted by DOC (Insurance Code Section 10133.5) while DOC's group health coordination of benefits regulations are required to be consistent with those of DOI (Insurance Code Section 10270.98). It must be remembered that the bulk of the Insurance Commissioner's regulations do not relate to the expense-incurred hospital, medical and surgical insurance which most closely parallels the coverage provided by Knox-Keene plans. Finally, the drafting of regulations in the area of potential conflict is handled by one senior attorney in my Department and it does not appear to me to be necessary for him to draft a policy for his own direction in carrying out this statute.

I do not foresee a need to consult with agencies other than DOC at this time.

> "5. In your view, what responsibility does your department have in ensuring a level of health care quality and service? How do you administer that responsibility? What level of health care quality and service have you established as the criteria to measure licensee performance?"

RESPONSE: The Insurance Code makes no mention of a DOI obligation to regulate affirmatively the quality and service of health care provided by or in behalf of its licensees. For exclusive provider arrangements, the Commissioner is required to, and has adopted, regulations establishing minimum standards for accessibility of exclusive provider services. (Insurance Code Section 10133.5; Title 10, Administrative Code Section 2240, et seq.) Insurance Code Section 10133(d) requires that third party continuous review of quality of care, etc., be provided for in contracts between insurers and providers. However, such contracts are not subject to DOI filing or approval.

Health care quality and service problems arising from contracts between DOI licensees and health care providers would be identified through the Department complaint-handling mechanism. This Department has 157 employees who are primarily responsible for handling complaints from the public against our corporate and individual licensees. In 1983, these persons handled 111,754 inquiries and complaints against insurance companies and insurance agents and administrators. (1984's figures are in preparation.) Although we lack direct authority

to regulate health care quality and service, I am confident that we would be able to take effective formal or informal action where an insurer had contracted with clearly inadequate or inferior providers.

> "6. How do you integrate the financial solvency and level of service factors in the regulation of persons, licensees and entities under your jurisdiction? Do you have regularly scheduled periodic audits for financial solvency? Do you have regularly scheduled periodic audits for health care quality and service? If you perform both, are they separate or are they an integrated audit? Please explain why you have adopted one policy procedure over another."

RESPONSE: Insurers are required by law to submit exhaustive standardized annual statements of their financial condition to be are audited by my Department. My Department requires quarterly and sometimes monthly financial statements from those disability insurers which it feels must be monitored more closely. Insurers also undergo triennial on-site examinations of all aspects, financial and service, of their operations. Finally, my Department conducts "market conduct examinations", as needed, of insurers which have demonstrated unusual complaint levels or which otherwise have drawn attention to their marketing and claims activities. My Department lacks the authority and expertise to audit the quality of health care rendered by providers contracting with our licensees. (See Tab 6.)

> "7. In the area of licensing, what tests (objective standards) do you apply to your licensees? Please identify those factors (tests) for maintaining a license and for obtaining a license."

RESPONSE: Most of the matters my Department analyzes and reviews, in connection with determining the eligibility of an insurer to receive a California Certificate of Authority, arise under statutory authority found in Insurance Code Sections 717 and 718 and do not involve objective tests, but rather a subjective determination of the sufficiency and adequacy of the legal and financial arrangements of the company. This is necessary because of the wide variety of applications we look at and possible company arrangements. It is not inherently possible to reduce all of the matters concerning the adequacy and reasonableness of the company's arrangements for the maintenance of its financial position, its reinsurance agreements, corporate status and other matters listed in Sections 717 and 718 to a series of objective standards or a checklist. It is a matter of bringing to bear expertise, past experience, and analytical ability to each individual fact situation.

I. Certificate of Authority Requirements

(a) Minimum capital/surplus for life and disability insurer (Insurance Code Sections 10510 and 10511).

(b) Three-year seasoning or exceptions, if foreign applicant. (Insurance Code Section 716). ("Foreign" companies are those domiciled in other states or possessions of the United States.)

Basic General Criteria (involves some subjectivity)

(a) Insurance Code Sections 717-718 (Qualifications): no material deficiencies respecting (a) capital and surplus; (b) investments; (c) financial stability; (d) reinsurance; (e) management competency, character, integrity; (f) ownership and control of shares; (g) claims adjustments; (h) business plans; (i) promotion methods; (j) policyholders/creditor hazard; affiliate's reputation.

Other Threshold Requirements

(a) Name or dba approved by Commissioner (and transacting solely under the name or dba) (Insurance Code Sections 880, et seq.).

(b) Corporate form (Insurance Code Section 699); par value (Insurance Code Section 690); corporate authority for classes sought (Insurance Code Section 680); certain criminal actions involving management of the company and the Commissioner's authority to decline to grant, suspend or revoke a license (Insurance Code Section 704.5); no government ownership (Insurance Code Section 699.5); appointment of agent for service of process, if foreign (Insurance Code Sections 1600, et seq.).

(c) Retaliation (if foreign) to impose upon applicants the same requirements imposed on California insurers in applicants' home state (Insurance Code Section 685).

The maintaining of the Certificate of Authority to do business in the State of California involves many Insurance Code Sections and basically our monitoring involves financial surveillence of the activities of the licensed insurer. The financial concerns of the company are not the only means provided for under the Insurance Code to suspend or revoke a license, but most of the time when the license is suspended or revoked it is due to financial problems.

II. Continuing Compliance with the Requirements to do Business in this State

(a) Insurance Code Section 700(c) provides that after the issuance of the Certificate of Authority, the holder shall continue to comply with the requirements as to its business set forth in the California Insurance Code and the other laws of this State. We may proceed to hearing to revoke a license if we find that the insurer has violated these requirements.

(b) The Commissioner may suspend a Certificate of Authority when he finds that the insurer is conducting its business fraudulently, not carrying out its contracts in good faith, or has habitually compelled insureds or liability judgment creditors of the insured, to accept less than what the policy provides for, or has habitually forced them into litigation to secure payment of claims for which liability has become fixed.

(c) Under Insurance Code Section 704.5, the Commissioner may decline to grant or may suspend or revoke a Certificate of Authority where it is found that the management of company has been convicted of, or pleaded guilty or nolo contendere to, certain specific types of crimes.

III. Monitoring of Financial Condition From a practical standpoint, monitoring is achieved primarily through financial surveillence of the activities of licensed insurers.

(a) Financial Statements. (Insurance Code Sections 900-922.15 and 923) To be filed annually; insurer must report financial condition on a calendar year statutory basis, on prescribed forms per NAIC accounting standards, which differ from GAAP. Also, in connection with life and disability insurers, domestics file Quarterly Statements and foreign life and disability insurers must file quarterly if the Department has concerns with regard to their financial condition.

(b) Financial Examinations. (Insurance Code Sections 730-738) The Commissioner may examine a company at will; he shall have full access to all books, papers and records; insurer must pay for examinations.

(c) Reserves. (Insurance Code Sections 997, 10489.1-10489.10) Minimum reserves and reserve methods for disability and life policies.

(d) Reinsurance. (Insurance Code Sections 620, et seq., 803, 1260, 922.3-922.8, 1011(c), 1101.1) Basic incidents of, and requirements for, valid reinsurance agreements eligible for annual statement credit.

The California Insurance Code is replete with statutory limitations and restrictions imposed upon admitted insurers, and I am responsibile for enforcing such limitations and restrictions as a condition of the maintenance of the outstanding Certificate of Authority.

IV. Investments

Domestic insurers, in order to obtain and retain the Certificate of Authority, must comply with the California Insurance Code standards. Admitted foreign insurance companies, though not required to comply with all of the investment requirements imposed upon domestic insurers, must meet the standards established under Insurance Code Section 717, including under subsection (b) the lawfulness and quality of investments and financial stability under subsection (c). If the investments do not comply, the insurer will not receive annual statement credit for the investments.

(a) Investments must be held in the insurer's own name (Insurance Code Section 1100), and in-state (Insurance Code Section 1104.1), if domestic; be adequately liquid to meet obligations (Insurance Code Sections 1153, et seq., and 706.5), and comply with certain standards for valuation (Insurance Code Sections 1250, et seq.).

(b) Limits on real estate investments (Insurance Code Sections 1150-1151.6) - only as needed for insurer's own business operations or if acquired by operation of law, or if permitted as "leeway law" investments under Insurance Code Section 1210.

(c) Paid-in capital must be invested in specified liquid investments, namely government agency - issued or backed debt instruments, called "general investments" (Insurance Code Sections 1170-1182).

(d) Remainder of assets must be invested in other specified debt, equity or loan investments called "excess investments." (Insurance Code Sections 1190-1194.95). All "excess investments" must meet certain standards of soundness (Insurance Code Sections 1195-1202).

(e) Large insurers can invest a limited portion of their assets in investments other than those listed in (c) and (d), above, as long as they comply with certain other standards (Insurance Code Sections 1240, et seq.).

V. Corporate Transactions

Certain corporate transactions by licensed insurers are monitored on an ongoing basis.

(a) Mergers; bulk reinsurance; sales and cessions; consolidations; etc. (Insurance Code Section 1011(c)) Commissioner's prior consent needed if insurer seeks to merge with or transfers substantial portion of its business to another insurer.

(b) Servicing of policies (Insurance Code Sections 810, et seq.) Commissioner's consent needed if insurer seeks to arrange for nonadmitted entity to service policies.

(c) Dividends (domestics only) (Insurance Code Sections 1152, 1215.5) Basic standards for declarations of dividends; Commissioner's approval needed for certain very large dividends.

(d) Holding company transactions (Insurance Code Sections 1215.5, et seq.) If company is domestic or a "commercial domiciliary," it must report specified information regarding relations and transactions with parent or affiliate corporations and/or other controlling persons (nondomestics must file similar reports); obtain Commissioner's consent to any change of control or ownership interest; and obtain Commissioner's consent to certain "material" transactions involving large amounts of insurer's assets. It also limits and regulates the investment in subsidiaries.

(e) Withdrawals (Insurance Code Sections 1070, et seq.) Company may withdraw only with Commissioner's permission after proof that existing liabilities are adequately retired or otherwise taken care of.

(f) Insurers are generally subject to the California Corporations Code (Sections 1140, et seq.).

VI. Securities

The Insurance Commissioner has jurisdiction over the offering of securities by insurers in this State.

(a) Security Permit (Insurance Code Sections 820, et seq.). No issuance of securities by domestic insurers, and no issuance to California residents by any insurer, without the Commissioner's permission.

(b) The offering must be fair, just and equitable.

(c) Proxies (Insurance Code Sections 1140-1140.5). To be filed with the Commissioner, unless insurer files with SEC or is closely held, as defined by statute.

(d) Insurer insider activities and trading (Insurance Code Sections 1104.2-1104.8). Parties with controlling interest or management positions must file certain disclosure statements, and cannot profit from inside information or engage in certain types of stock sale unless stock is SEC-registered, or company is closely held.

VII. Management Conflict-of-Interest

Insurance Code Sections 1101-1104 and 1105 deal with conflicts-of-interest and give the Commissioner certain authority in connection therewith. Directors, officers and key managerial persons cannot have personal economic interest in transactions involving insurers, such as purchases, sales and loans, with certain exceptions.

The Insurance Code is replete with sections concerning both the admission of insurers and the ongoing monitoring of the activities of insurers. Those sections listed above are the major sections that we deal with on a fairly regular basis.

The statutory qualifications and standards applicable to insurance producers are set forth in Insurance Code Sections 1666 et seq. at Tab 7.

"8. What disclosure requirements do you current[ly] apply on the products offered to the general public by your licensees? What additional disclosure requirement do you feel should be added by either administrative regulation and/or by statute, and why? Should there be established a common set of disclosure requirements to be applied to your licensees?"

RESPONSE: The Health Insurance Disclosure Act of 1974, Insurance Code Sections 10600 through 10609, requires that uniform outlines of coverage be provided when health insurance products are solicited. These outlines of coverage are set forth in the Insurance Commissioner's regulations, Title 10, Administrative Code 2540, et seq. Parallel requirements apply to Knox-Keene plans. Also, health insurance product advertising is governed by a comprehensive set of regulations designed to ensure that such advertising is neither deceptive nor misleading. (Title 10, Administrative Code, §§2535-2537.2)

All individual health insurance policies and group master policies delivered in California must be approved by my Department before issue. Insurance Code Section 10291.5(b)(1) states that the Insurance Commissioner shall not approve any

such policy "...if he finds that it contains any provision, or has any label, description of its contents, title, heading, backing or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued." My Department often disapproves policies on the basis that some provision is "likely to mislead" an insured. A common means of complying with such an objection is to improve the disclosure of the operation of the objected-to policy provision.

Title 10, Administrative Code Section 2240.3 requires special disclosure of certain aspects of the operation of exclusive provider arrangements in group insurance plans. Note specifically, subsection (c) requiring "...a brief and prominent warning reflecting the limitations in the group contract pertaining to exclusive provider services..." and the specific requirements for such warning set forth therein.

I do not believe that common disclosures are necessary. My experience has been that the insured public is fairly sophisticated concerning the distinction between Knox-Keene plans and "freedom-of-choice" insurance plans, and these distinctions are generally emphasised in the advertising and solicitation of the respective types of programs. It is only where an insurance program contains restrictions on freedom of choice more characteristic of health care service plans that some sort of special disclosure is needed and is required, as noted above. Such disclosure would probably be superfluous in a health care service plan document.

Another consideration is that hospital, medical and surgical coverage comparable to that of Knox-Keene plans is only one of the many types of disability insurance subject to DOI's policy approval, disclosure form and advertising requirements. Finally, it should be noted that an ever-increasing proportion of California citizens, particularly those receiving coverage through their unions or through large employers, are entirely beyond the reach of protection through state regulation, because of ERISA preemption.

> "9. What role do you see for your department in addressing the claim of federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA) by persons or health entities claiming lack of state jurisdiction by your department. Have your attorneys researched and provided you a formal written opinion on whether or not persons or entities, which claim your agency lacks jurisdiction due to ERISA, are correct or incorrect in their claim? If so, what have been their conclusions and have you used these opinions as the basis for departmental policy?"

RESPONSE: My Department's role in addressing the claim of ERISA preemption results from the Federal Government's failure to administer adequately ERISA itself. As it appears that such failure will continue indefinitely, the Department has undertaken the task, cooperatively with DOC, of identifying, locating and investigating self-funded health benefit programs operating in California that are not known to be union welfare, single employer or collectively-bargained plans. Our activities in this regard are explained in detail throughout this letter and the Appendix. See also, Tab 9.

> "10. AB 3342 (McAlister - Chapter 640, Stats. 1984) took immediate effect on August 16, 1984. How have you implemented this measure? What written procedures and policies have you established? What additional duties or responsibilities have you undertaken to yourself or a specified individual in implementing this measure? Have you used the provisions of AB 3342 in an investigative or enforcement action since its enactment?"

RESPONSE: AB 3342 has not yet been a factor in our current investigations of PPOs. The subjects of those investigations all seem to have accepted our jurisdiction and the legislation would only be a factor if there were to be a dispute in the future. My Department has initiated several investigations of PPO-type organizations in 1984, most of them prior to the effective date of AB 3342. Thus, we have not yet needed to establish any specific written procedures or policies arising from this legislation.

> "11. Regarding the "coordination of health insurance benefits" issue, how do you view AB 3342 provisions in assisting your department with its enforcement actions? In particular, what role has or will your department play in assisting persons, licensees and entities under your jurisdiction to assure coordination of benefit payments in the "Valley Clerk's Trust Fund" case located in San Joaquin County? Additionally, what steps has your department taken to implement the provisions of SB 2024 (Maddy - Chapter 1066, Stats. 1982)?"

RESPONSE: I do not see that AB 3342 substantially added to Senator Maddy's SB 2024 of 1982. The Valley Clerk's Trust Fund appears to be a legitimate exempt ERISA entity in addition to being exempt from the Insurance Code under Section 10505. Although it could be argued that recent legislation modifies the latter exemption somewhat, I believe that ERISA pre-emption makes that question moot.

"12. AS you know, Insurance Code Section 740 was added by AB 2670 (McAlister, Chapter 706, Stats. 1982). SB 952 (Robbins, Chapter 277, Stats. 1983) strengthen this section and required licensure under specified conditions. These measures deal with presumed jurisdiction to the Department of Insurance over multiple employer trust (METs) unless the entity or person is regulated under the Knox-Keene Health Plan Act of 1975. Since these measures took effect in September 1982 and in 1983, what changes in statutory language, if any, has your department proposed as the result of implementing these measures?"

RESPONSE: My Department has not proposed any changes in the statutory language of the legislation discussed, although we have offered our opinions about certain aspects of these bills in our Legislative Analyses.

"13. Relating to question 12, since the enactment of AB 2670, how have you implemented this measure? What written procedures and policies have you established to address the overlapping jurisdiction by your Departments? How have you integrated your consumer complaint, enforcement, investigations, financial analysis, and legal activities in your Department in implementing AB 2670?"

RESPONSE: Included under Tab 13 are copies of my 1983 and 1984 reports to you: "Report on the Effectiveness on the Enforcement of Insurance Code Section 740". The procedures and policies of enforcement set forth in those reports remain the same while our effectiveness has improved. The initial memo setting up the MET project is also attached, as is the most recent set of public lists required by the legislation.

Two more stop orders were issued in 1984, both successfully controlling illegal METs: RDA and TOTALCARE. Three more entities have been referred to our Legal Division for formal regulatory action, such as cease and desist orders. Various license revocation and criminal actions were either taken or begun against the perpetrators of ABT in 1984. At least one more MET cease and desist order is in the report writing stage and three other investigations should be completed in the first quarter of 1985.

Our success rate in resolving consumer complaints against self-funded entities is low, except in instances where we have not yet moved to force regulation, or where (as in IBT) there is an ongoing legal battle. In these cases, we have been reasonably successful in getting claims paid. Typically, where an unlicensed entity such as an MET litigates our assertion of jurisdiction, we have had to bring extremely complex fact and

law situations into focus for the Deputy Attorney General handling the case. This is very time consuming and usually results in several areas of misunderstanding between my Department and the Attorney General. I would much prefer to use house counsel in cases of this kind, as our own legal staff is experienced in the application of the Insurance Code and in the structure of the insurance business. This would result in staff and budget savings and more effective regulation.

> "14. Relating to question 12, how does your department define the following terms used in Insurance Code Section 740: "entity," "services," "coverage," and "regulated?" If the statute language was changed from "providing coverage in this state" to "providing services in this state" how would your interpretation and definition change?"

RESPONSE: "Entity": Any thing or being in existence including, but not limited to, individuals or groups operating under real or fictitious names, and/or as corporations, partnerships, associations, etc.

"Coverage" has a very broad and general meaning in the insurance industry. In the context of Sections 740, et seq., a working definition might be "a form of protection provided by an assumer of risk against a covered person's risk of loss resulting from the treatment of a physical or mental condition."

"Services": Coverage in the form of institutional or professional services rendered to covered persons directly by the assumer of risk or by institutional and/or professional providers by arrangement with the assumer of risk. To be distinguished from "indemnity".

"Indemnity": Coverage in the form of financial indemnification against the covered person's liability to institutional and/or professional providers for services rendered.

"Regulated": Governed or controlled by law, rule or constituted authority.

If the wording of Section 740 were changed from "coverage" to "services", then it is likely that one would interpret the section as applying to service plans under Knox-Keene as opposed to insurance plans under the Insurance Code. At the very least, the section would be so ambiguous as to create serious enforcement problems.

> "15. In the past we have asked your Department to provide us with results of enforcement actions under Insurance Code §740. From the enactment date of AB 2670 and SB 952, please provide a list of all formal investigative and enforcement actions undertaken by your Department pursuant

to Insurance Code §740. For formal actions, please specify the person or entity and the results of your actions. What number of investigating actions are currently underway and what is their status? In your view, what proposed modifications do you suggest to Insurance Code §740 and any other Code section which have statutorily prevented you from more effective enforcement? Are you prevented from taking more effective enforcement action because there are operative sections in both the Health and Safety and Insurance Codes?"

RESPONSE: Formal Enforcement Actions

Consumers Association of Medical Protection	Cease and Desist Order
Total Care	Cease and Desist Order
American Benefits Trust	Bankruptcy, receivership, license actions and criminal arrests
IDA	Cease and Desist order
Insurance and Prepaid Benefits Trust	DOI enjoined from conservation/ liquidation; in litigation
New World Maintenance Assn.	Cease and Desist Order
CARE	Conservation/Liquidation
GHP	Joint Receiver with DOC.

Formal Investigations: approximately 350; no list available at this time.

Number of Investigations Pending: approximately 100.

We may have to consider modification of Section 740 depending on the outcome of the IBT litigation.

"16. The provisions of AB 2347 (McAlister - Chapter 947, Stats. 1984), which took effect August 27, 1984, and AB 3342, which took effect August 15, 1984, address the overlapping jurisdiction issue. Specifically, language in added Insurance Code §742 and amendments to Insurance Code §1759 provide for "subject to regulation" for any person or entity under the Knox-Keene Health Plan of 1975. As you are aware, when Insurance Code 740 was enacted, the word "regulated" was used. Section 740 language has been changed to "subject to regulation." In your view, do you find any difference in your interpretation of the word

"regulated" with the new language of "subject to regulation?" If yes, why? If no, why not? Do you believe a licensee, person or entity could be subject to both of your Departments' jurisdiction at the same time? If yes, what written policies or procedures have you adopted to address this concurrent jurisdiction?"

RESPONSE: The term "regulated" implies that the regulator is actively engaged in governing the affairs of the regulatee, whereas, the phrase "subject to regulation" implies merely that there are laws or rules that must be adhered to by the regulatee. "Subject to regulation" does not, in and of itself, require that the regulator actively regulate the regulatee. In other words, a person or entity could be "subject to regulation" without really being "regulated".

About the only instance of a legally-operating "licensee, person or entity" being subject to the jurisdiction of both Departments is an administrator which chooses to contract with both insurers and Knox-Keene plans. Even here, the existence of "overlap" may be questionable, since the procedures used to administer insurance and service plans may differ enough that administrators will establish separate units to handle them.

"17. AB 2347 provisions add Insurance Code §742 and contain the term "preferred provider organization" (PPO). In your view, how do you define this term and how have you implemented this newly added Insurance Code section? Have you used the provisions of AB 2347 in an investigative action, interpretative opinion request, or enforcement action since its enactment?"

RESPONSE: Definition of PPO: A provider or a group of providers who, either themselves or through an intermediary organization or network, undertake to provide health care services on a fee for service basis to beneficiaries of a third party payor (insurer or other funding entity) at fees or rates stipulated in advance in a contract with the third party payor.

Section 742 has not been a factor in any investigation or enforcement action to date.

"18. AB 707 (Isenberg) was passed by the Legislature, but vetoed by the Governor. The Department of Corporations opposed the measure; the Department of Insurance took no position. In your view, how do you interpret the provisions of AB 707, which provides legislative intent that alternative rate contracts between purchasers or payors of health care services and institutional and out-patient providers are exempt from state and federal antitrust provisions? How do its provisions affect your licensees?"

RESPONSE: I have no position on this matter, since my Department does not enforce the anti-trust laws. I believe that Commissioner Tom's views on this bill have considerable merit, however.

"19. Relating to question 18, it has been contended by the California Attorney General's Office that absent regulation, PPO's are not exempt but subject to state antitrust provisions. It has also been contended that the U.S. Department of Justice and the Federal Trade Commission view a "pro-competitive" PPO as exempt from federal antitrust provisions. Based upon these two contentions, in your view does the absence of specific regulation by either of your Departments with respect to PPO's require immediate administrative and/or statutory designation of the regulator? Further, in the absence of a specific PPO regulator has a barrier to reducing health care costs been created?"

RESPONSE: I regard this as a policy matter for the Legislature to decide. This Department has maintained a generally neutral stance on the development of PPOs, recognizing that such arrangements may introduce a healthy element of competition into the provision of medical services while being concerned that the concept may be perverted or exploited by those whose primary interest is personal gain. Thus, we take no position as to whether legislation should be enacted which would promote the growth of PPOs. I note with interest Commissioner Tom's analysis of this issue and the recent article in the Health Lawyers News Report included under Tab 19.

"20. In your previous written responses to us on the Legislative Counsel's opinion on preferred provider organizations, there has been some discussion raised over whether you have jurisdiction. Given the fact that you may have jurisdiction, what do you believe would be the appropriate level of regulation? Should there be a full regulatory program? Should there be a limited program to require adhering to administratively adopted standards of conduct after public hearings are conducted? Or, do you believe preferred provider organizations should be subject to a registration only program requirement? In what state agency should this registration occur? What role should your Department and the Department of Health Care Services and the Office of the Attorney General play in any type of regulatory program?"

RESPONSE: The principal area of public complaint concerning PPOs so far has been Blue Cross' conversion of its individual business to a PPO basis. (We have received few, if any, complaints concerning conversion of group cases to PPO plans.) Initially, we were concerned about a movement of entrepreneurs

from the uninsured MET field into PPOs, but this has largely abated, apparently because these persons were unable to identify cash flows which could be readily diverted to their own use. On the other hand, we are closely watching certain small domestic insurers which have previously issued little group health insurance and which are now heavily involved in group PPO programs, often in association with promoters who have come to our attention in the past. There are no jurisdictional issues in these cases and the regulatory concerns are squarely within the purview of the mechanisms in the Insurance Code for dealing with solvency issues.

I think it would be unwise to propose a "full regulatory program" for PPOs because this method of providing for health care services has not yet "shaken out". It is too early to tell what the real problems with these arrangements will be. Also, we do not know where the real power to influence the shape of the services provided under preferred provider arrangements will rest. Will PPOs see themselves as competing with HMOs and emulate their structure and services, or will they try to be more like freedom-of-choice programs? If they tend in the former direction, then we can expect centralized direction and control of the provision of services by the organization. If they tend to take the latter tack, then we would expect individual providers to retain a high level of independence and we would assume that their service decisions would be based on traditional practices within the medical profession. Of course, we may see organizations going both ways. However, I would personally expect PPOs to trend in the direction of provider independence, because there seems to be little in the way of a market niche for entities which provide services in much the same manner as the well-entrenched HMOs.

> "21. Today, in the marketplace we find a nonprofit hospital service plan or insurance company creating a health maintenance organization or health care service plan. This results in separate but overlapping jurisdiction by your Departments. In your view, should there be a common formal procedure for monitoring these licensees by your Departments? If yes, how would you implement such a proposal?"

RESPONSE: I am unaware of any serious problems which the public has experienced because of the parallel jurisdiction to which separate functions of some entities are subject. As indicated previously, virtually all organizations subject to parallel jurisdiction are organized into separate units, some of which are subject to DOI jurisdiction and some of which are subject to DOC jurisdiction. I know of no instance in which the same legal entity is licensed by both our Departments. (DOC does not license "administrators".) In any event, the

regulatory schemes mandated by the Insurance Code and the Knox-Keene Act are so different that a "common formal procedure" for monitoring affiliates licensed under the respective laws would be impractical.

"22. During the 1983-84 Legislative Session, numerous bills dealing with mandated health coverage were amended to exempt specific licensees, such as health maintenance organizations, from their provisions. In your view, should organizations, such as Kaiser, Blue Shield, and Blue Cross, be exempted from these bills' provisions?"

RESPONSE: In general, this Department believes that competitors in the health care market should be subject to the same coverage mandates. We have usually opposed mandated benefits except where they clearly benefited insureds rather than a particular class of providers, such as the continuation and replacement law and the conversion law. In general, Blue Cross is subject to the same mandates as stock and mutual insurers under the Insurance Code.

"23. In the area of complaints from the general public as it relates to health coverage, please provide specific data on the number of complaints and the complaint subject matter referred by the Department of Insurance to the Department of Corporations and vice versa based on grounds of jurisdiction. Regarding medical malpractice insurance coverage by providers, what role do you believe you have in determining this issue? In your view, do you believe there should be a formal procedure for handling consumer complaints where overlapping jurisdiction exists?"

RESPONSE: We have received only occasional complaints that should have gone to DOC. They are referred directly to the proper agency on an informal basis. We do not maintain any statistics on this and I do not believe that any formal procedure needs to be developed in this area.

I do not see any necessity for DOI to involve itself with medical malpractice coverage on contract providers. In any event, I understand that most provider contracts require that the provider maintain such coverage.

"24. Within your own Department, how do you integrate your enforcement, and legal activities with the receipt of consumer complaints relating to health coverage? Do you involve your licensing and financial audit activities?"

RESPONSE: As indicated above, my Department has a well-established system for handling consumer complaints. Legend has it that the first person the new Insurance Commissioner hired in 1867 was someone to handle consumer complaints.

My Department contains units responsible for (1) investigating illegal METs; (2) investigating improper activities by health insurers or agents; (3) resolving consumer complaints; (4) resolving claim problems; and (5) resolving rating problems. Each unit may receive and handle a consumer complaint. A system exists for tracking and referral of relevant information to the other units which may have an interest, including financial audit (Field Examination) and the market conduct unit. Consumer complaints against producers are also investigated for possible formal action.

> "25. In your view, what jurisdiction authority do you have over administrators, medical care foundations, solicitors, solicitor firms, and exclusive provider organizations? Please provide a list of the factors used in defining each of these entities."

RESPONSE: We have jurisdiction over administrators pursuant to Insurance Code Sections 1759-1759.10. Foundations for medical care, solicitors and solicitor firms are regulated under the Knox-Keene Act. Preferred and exclusive provider organizations associated with insurance companies may be reached through the insurers. Consumer complaints are dealt with by contacting the insurer whose policy is involved.

Administrators are defined in Section 1759. See Tab 25.

> "26. The Department of Insurance's August 22 correspondence raised the possibility that PPO's might engage in certain activities bringing them within the Department's jurisdiction over insurance administrators. In view of this possibility, what has your Department undertaken to develop internal written procedures and policies to alert your Department personnel to watch for specified activities? What has the Department undertaken to publicly inform its licensees, in particular administrators, of the potentiality of their actions? What steps do you propose administratively or legislatively to address this potentiality?"

RESPONSE: My investigators have been instructed to bring in as much information as practical concerning the PPOs they encounter. So far, they have not found any that adjust claims. Typically, the first thing a person contemplating the establishment of a PPO does is to call my Department and ask about licensing. Some items have appeared in the trade press erroneously indicating that my Department "licenses" PPOs, which, of course, it does not.

"27. The Department of Corporations is in receipt of the Department of Insurance's August 22 correspondence. Further, pursuant to Ab 160 (McAlister, Chapter 830, Stats. 1983) provisions, the Department of Corporations has communicated to solicitors and solicitor firms. In view of these developments, what is the Department of Corporations' view on the possibility that PPO activities may cause them to be within the Department's jurisdiction over activities of solicitor and solicitor firms? Has the Department of Corporations undertaken any administrative action or issued interpretative formal opinions, etc. to inform its licensees of the potentiality of their actions?"

RESPONSE: Not applicable to DOI.

"28. Your Departments have indicated an informal development of information on PPO's procedure exists. What is your Department's assessment of PPO growth, potentiality for unfunded risk, etc., based on your information gathered? What is the status of your formal process to exchange information?"

RESPONSE: PPOs are already widespread in areas where there is significant competition among medical providers. One cannot forecast at this time whether PPOs will be viable in areas lacking such competition.

The potentiality for unfunded risk is slight for a PPO operating with an insurer or other lawful third-party payor (such as a Knox-Keene plan or a legitimate self-funded ERISA plan), unless the third-party payor fails.

An entity calling itself a "PPO" but operating without the backing of a third-party payor will almost always fit the definition of a health care service plan and will be of concern to DOC.

Please refer to my response to Questions 2 and 3 for a description of our liaison with DOC on PPOs.

"29. Some health care service plans have a substantial indemnity component in their operation, either as a basic part of their activities or to provide for out-of-area coverage or coverage for services which a health care service plan does not want to provide for itself. For example, Blue Shield has a substantial indemnity component in their operation. Kaiser Foundation Health Plan provides

dental benefits strictly on an indemnity basis. Insurers and nonprofit hospital service plans are purchasing health care service plans. Some health care service plans have purchased insurers. In view of these developments, what is your view of establishing a formal common monitoring procedure and applying identical objective standards over these licensees? What leads you to your conclusion?"

RESPONSE: As indicated above, it does not seem to me that "formal common monitoring procedures" or "identical objective standards" are required for organizations whose functions may be subject to parallel jurisdiction. The statutory and regulatory schemes applicable to the various activities of such organizations are well tailored to the differences in the way they operate and in the way they provide for risk. Furthermore, these schemes have been carefully refined over the years.

A truly massive statutory recodification would be necessary in order to "apply identical objective standards" to the various functions of the entities subject to the jurisdiction of our respective Departments. In addition, the health care benefits industry is changing very rapidly at this time, and such a recodification would very probably be obsolete by the time it was completed.

"30. In your view, if you have concluded you do not want to transfer your jurisdiction in whole or in part to the opposing Department or any other state agency, what benefit(s) do you believe that you provide to your licensees and to the public which cannot be provided in whole or in part by another state agency?"

RESPONSE: As the establishment of the Division of Health Care Service Plans in DOC demonstrates, any regulatory agency can be assigned the responsibility for regulating a particular business activity if the Legislature so directs.

I hope the foregoing comments are enlightening.

BRUCE BUNNER
Insurance Commissioner

BB:ams

Enclosure

TAB 6

Note: Stats. 1974, Ch. 374, also contains the following provisions:
SEC. 22. This act may be cited as the Berryhill Total Compensation Act.

699.5. A certificate of authority shall not issue to any insurer owned, operated or controlled, directly or indirectly, by any other state, or province, district, territory or nation or any governmental subdivision or agency thereof.
(Added by Stats. 1957, Ch. 190.)

700. (a) A person shall not transact any class of insurance business in this state without first being admitted for such class. Such admission is secured by procuring a certificate of authority from the commissioner. Such certificate shall not be granted until the applicant conforms to the requirements of this code and of the laws of this state prerequisite to its issue.

(b) The unlawful transaction of insurance business in this state in willful violation of the requirement for a certificate of authority is a public offense punishable by imprisonment in the state prison, or in a county jail not exceeding one year, or by fine not exceeding one hundred thousand dollars ($100,000), or by both, and shall be enjoined by a court of competent jurisdiction on petition of the commissioner.

(c) After the issuance of a certificate of authority, the holder shall continue to comply with the requirements as to its business set forth in this code and in the other laws of this state.

(d) Where a hearing is held under this section the proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.
(Amended by Stats. 1978, Ch. 795.)

700.01. In addition to any or all of the classes of insurance which it is permitted to transact by all other applicable provisions of this code, any incorporated insurer admitted or hereafter admitted for one or more of the classes of insurance stated in Section 100, except life, title, mortgage, or mortgage guaranty shall (subject to any limitations contained in its articles of incorporation or charter) be admitted after October 1, 1953, for any or all of the following classes, upon making application therefor and complying with all applicable requirements of law, if its paid-in capital is not less than one million three hundred thousand dollars ($1,300,000) or the aggregate of the amounts hereinafter set forth opposite the classes transacted by it in the United States if an alien insurer, or in any jurisdiction if other than an alien insurer, whichever is lower; provided, that the paid-in capital of incorporated insurers not transacting either fire, marine or surety insurance making application under this section shall be at least one hundred fifty thousand dollars ($150,000) in excess of such aggregate amount. In no event shall any incorporated insurer, as a condition for its admission, be permitted to have a paid-in capital of less than five hundred thousand dollars ($500,000) or be required to have a paid-in capital in excess of one million three hundred thousand dollars ($1,300,000) for any or all of the classes of insurance hereinafter set forth.

Number and name of class	Amount of capital
2. Fire	$200,000
3. Marine	200,000
5. Surety	250,000
6. Disability	50,000
7. Plate glass	50,000
8. Liability 9. Workers' compensation 10. Common carrier liability	100,000 for any or all of these
11. Boiler and machinery	50,000
12. Burglary	50,000
13. Credit	50,000
14. Sprinkler	50,000
15. Team and vehicle	50,000
16. Automobile	100,000
18. Aircraft	50,000
20. Miscellaneous	50,000

This section shall not be applicable to life, title, mortgage, or mortgage guaranty insurance, and an insurer now or hereafter admitted to transact life, title, mortgage, or mortgage guaranty insurance shall not be admitted under the provisions of this section, but its admission is governed by other applicable provisions of this code.

Insurers admitted for one or more classes of insurance on December 31, 1981, shall be governed by the provisions of this section in effect on December 31, 1981.

Insurers which were issued a permit prior to July 7, 1982, authorizing the organization of the insurer and which were admitted for one or more classes of insurance before January 1, 1983, shall also be governed by the provisions of this section in effect on December 31, 1981.

(Amended by Stats. 1983, Ch. 3. Effective February 18, 1983.)

700.02. No insurer shall be issued a certificate of authority other than a renewal certificate of authority for any of the classes set forth in Section 100 unless at the time of such issuance it possesses, in addition to the minimum paid-in capital required by this code a surplus of not less than 100 percent of the minimum paid-in capital required.

As used in this section, surplus means the excess of admitted assets over the sum of (1) liabilities for losses reported, expenses, taxes and all other indebtedness and reinsurance of outstanding risks as provided by law, and (2) paid-in capital, in the case of an insurer issuing or having outstanding shares of capital stock, or (3) the minimum paid-in capital required, in the case of any other insurer.

(Amended by Stats. 1982, Ch. 389.)

700.025. An insurer, including a reciprocal or interinsurance exchange, admitted on January 1, 1970, to transact automobile liability insurance under class 8 and automobile insurance under class 16, or which had a valid bona fide application to transact both such classes of insurance pending before the commissioner on or before August 1, 1970, shall not be affected by this section.

Any other insurer, including a reciprocal or interinsurance exchange, applying to transact either of such class of insurance in this state, shall possess, at the time of admission for either of such classes, in addition to all minimum paid-in capital required by Section 700.01 and all surplus and paid-in capital required by Sections 700.02 and 700.05, an additional surplus of two hundred thousand dollars ($200,000).

(Added by Stats. 1970, Ch. 544.)

700.03. Notwithstanding the requirements of Sections 700.01 and 10511 until June 30, 1955, the minimum paid-in capital required for renewal, for the same classes of insurance, of the certificate of authority of any insurer which was in effect on July 1, 1953, shall be that required by such sections as effective on such date. After June 30, 1955, and until such time as such insurer increases its paid-in capital to the amount required by Sections 700.01 and 10511 as effective on October 1, 1953, the minimum paid-in capital required for such renewal shall continue to be that required by such sections as effective on July 1, 1953, but such insurer shall be required to maintain a surplus, as defined in Section 700.02, in an amount which, when combined with the amount of its paid-in capital, shall equal the minimum amount of paid-in capital required by Sections 700.01 and 10511 as effective on October 1, 1953.

(Added by Stats. 1953, Ch. 958.)

700.04. Paid-in capital for life insurers is governed by Section 10510 of this code; for title insurers by Section 12359; for mortgage insurers by Section 12440; and for mortgage guaranty insurers by Section 12640.03.

(Added by Stats. 1965, Ch. 170.)

700.05. (a) In determining the minimum amount of paid-in capital and surplus required by the applicable provisions of this code for admission of an insurer, there shall be included all of the classes of insurance transacted by it in the United States if an alien insurer, or in any jurisdiction if other than an alien insurer; provided, that life, title, mortgage or mortgage guaranty insurance shall not be included among the classes of insurance in determining the minimum amount of paid-in capital and surplus required if the minimum paid-in capital is one million dollars ($1,000,000) or more, and if the paid-in capital is less than one million dollars ($1,000,000) the minimum shall be measured by adding to the amounts set forth in Section 700.01 four hundred fifty thousand dollars ($450,000) for life insurance, two hundred fifty thousand dollars ($250,000) for mortgage insurance, one million dollars ($1,000,000) for mortgage guaranty insurance and two hundred fifty thousand dollars ($250,000) for title insurance.

In applying such provisions, it shall be conclusively presumed that an insurer transacts all classes of insurance for which it is or seeks to be admitted to transact in this state.

(b) As used in this section, "insurer" includes a reciprocal or interinsurance exchange and its attorney in fact.

(Amended by Stats. 1965, Ch. 464.)

701. Subject to the annual fee provisions of Section 705, every certificate of authority shall be for an indefinite term and shall expire with the expiration or termination of a corporate existence of the holder thereof. Notwithstanding the provisions of this section, whenever the commissioner shall determine, after notice and hearing, that any insurer to whom such certificate has been issued is in arrears to the State, or to any county or city in the State, for fees, licenses, taxes, assessments, fines or penalties, accrued on business transacted in the State, or is otherwise in default for failure to comply with any of the laws of this State regarding the governmental control of such insurer by the State, he may order that such insurer comply with the said requirements within 30 days of such

(2) Any type of individual disability policy not included in one of the three types described in subdivision (b) and not included in paragraph (1) of this subdivision.

The minimum unearned premium reserve shall be the pro rata unearned portion of gross premiums in force and, subject to the limitations contained in Sections 922.2 to 922.8, inclusive, shall be reduced by premiums paid or credited for risks reinsured in solvent insurers.

(d) Provided the reserve on all policies to which the method or basis is applied is not less in the aggregate than the required amount determined according to the applicable standards specified in subdivisions (b) and (c), an insurer may use any reasonable assumptions as to the interest rate, mortality rates or the rates of morbidity or other contingency, and may introduce an assumption as to the voluntary termination of policies. Also, subject to the preceding conditions, the insurer may employ methods other than the methods stated in subdivisions (b) and (c) in determining a sound value of its liabilities under such policies, including but not limited to the following: (1) the use of midterminal reserves in addition to either the gross pro rata unearned premium reserves described in subdivision (c) or the net pro rata unearned premium reserve; (2) optional use of either the level premium, the one-year preliminary term or the two-year preliminary term method; (3) prospective valuation on the basis of actual gross premiums with reasonable allowance for future expense; (4) the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity; (5) the computation of the reserve for one policy benefit as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued; (6) the use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

For statement purposes the net reserve liability for active lives may be shown as the mean reserve with offsetting asset items for net unpaid and deferred premiums or it may be shown as the excess of the mean reserve over the amount of net unpaid and deferred premiums, or, regardless of the underlying method of calculation, it may be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

(Amended by Stats. 1981, Ch. 767.)

Article 14. Proceedings in Cases of Insolvency and Delinquency

(Article 14 amended by Stats. 1935, Ch. 291)

1010. The provisions of this article shall apply to all persons subject to examination by the commissioner, or purporting to do insurance business in this State, or in the process of organization with intent to do such business therein, or from whom the commissioner's certificate of authority is required for the transaction of business, or whose certificate of authority is revoked or suspended.

(Amended by Stats. 1935, Ch. 291.)

1011. The superior court of the county in which is located the principal office of such person in this state shall, upon the filing by the commissioner of the verified application showing any of the following conditions hereinafter enumerated to exist, issue its order vesting title to all of the assets of such person, wheresoever situated, in the commissioner or his successor in office, in his official capacity as such, and direct the commissioner forthwith to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business of said person, or so much thereof as to the commissioner may seem appropriate, and enjoining said person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until the further order of said court:

(a) That such person has refused to submit its books, papers, accounts, or affairs to the reasonable inspection of the commissioner or his deputy or examiner.

(b) That such person has neglected or refused to observe an order of the commissioner to make good within the time prescribed by law any deficiency in its capital if it is a stock corporation, or in its reserve if it is a mutual insurer.

(c) That such person, without first obtaining the consent in writing of the commissioner, has transferred, or attempted to transfer, substantially its entire property or business or, without such consent, has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(d) That such person is found, after an examination, to be in such condition that its further transaction of business will be hazardous to its policyholders, or creditors, or to the public.

(e) That such person has violated its charter or any law of the state.

(f) That any officer of such person refuses to be examined under oath, touching its affairs.

(g) That any officer or attorney in fact of such person has embezzled, sequestered, or wrongfully diverted any of the assets of such person.

(h) That a domestic insurer does not comply with the requirements for the issuance to it of a certificate of authority, or that its certificate of authority has been revoked; or

(i) That the last report of examination of any person to whom the provisions of this article apply shows such person to be insolvent within the meaning of Article 13 (commencing with Section 980), Chapter 1, Part 2, Division 1; or if a reciprocal or interinsurance exchange, within the applicable provisions of Section 1370.2, 1370.4, 1371, or 1372; or if a life insurer, within the applicable provisions of Sections 10510 and 10511.

(Amended by Stats. 1974, Ch. 447.)

1011.5. The consent described in Section 1011(c) shall be obtained by filing an application with the commissioner in a form to be prescribed by him accompanied by such additional information concerning the insurer, its condition and affairs as the commissioner requires.

A fee of two thousand two hundred fifty dollars ($2,250) shall be paid to the commissioner for the filing of the application.

(Amended by Stats. 1981, Ch. 1131.)

1012. Said order shall continue in force and effect until, on the application either of the commissioner or of such person, it shall, after a full hearing, appear to said court that the ground for said order directing the commissioner to take title and possession does not exist or has been removed and that said person can properly resume title and possession of its property and the conduct of its business.

(Amended by Stats. 1935, Ch. 291.)

1013. Whenever it appears to the commissioner that any of the conditions set forth in section 1011 exist or that irreparable loss and injury to the property and business of a person specified in section 1010 has occurred or may occur unless the commissioner so act immediately, the commissioner, without notice and before applying to the court for any order, forthwith shall take possession of the property, business, books, records and accounts of such person, and of the offices and premises occupied by it for the transaction of its business, and retain possession subject to the order of the court. Any person having possession of and refusing to deliver any of the books, records or assets of a person against whom a seizure order has been issued by the commissioner, shall be guilty of a misdemeanor and

1063.13. No member insurer of the association shall engage in the unlawful trade practice defined and condemned in subdivision (g) of Section 790.03.
(Added by Stats. 1970, Ch. 1205.)

1063.14. (a) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain provisions whereby each member insurer is required to recoup over a reasonable length of time a sum reasonably calculated to recoup the assessments paid by the member insurer under this article by way of a surcharge on premiums charged for insurance policies to which this article applies. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

(b) The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. Billings or declarations covering policies of insurance subject to the provisions of Section 660, including, but not limited to, the policies described in subparagraphs (i) and (ii) of paragraph (2) of subdivision (a) of Section 660, or 675 need not separately state a surcharge. The association shall determine the rate of the surcharge and the collection period for each category and these shall be mandatory for all member insurers of the association who write business in those categories. Member insurers who collect surcharges in excess of premiums paid pursuant to Section 1063.5 for an insolvent insurer shall remit the excess to the association as an additional premium within 120 days after the end of the collection period determined by the association. The excess shall be applied to reduce future premium charges for that insurer in the appropriate category.

(c) The plan of operation may permit a member insurer to omit collection of the surcharge from its insureds when the expense of collecting the surcharge would exceed the amount of the surcharge. However, nothing in this section shall relieve the member insurer of its obligation to recoup the amount of surcharge otherwise collectible.
(Amended by Stats. 1983, Ch. 308.)

Article 14.5. Stop Order Power of the Commissioner
(Article 14.5 added by Stats. 1965, Ch. 1579)

1065.1. Whenever the commissioner has reasonable cause to believe, and determines, after a public hearing, that any person specified in Section 1010 is conducting its business and affairs in such a manner as to threaten to render it insolvent, or that it is in a hazardous condition, or is conducting its business and affairs in a manner which is hazardous to its policyholders, creditors or the public, or that it has committed or engaged in, or is committing or engaging in, any act, practice, or transaction which under any provision of this code would constitute ground rendering the person subject to conservation or liquidation proceedings, he may make and serve upon the person such order or orders as shall be reasonably necessary to correct, eliminate or remedy such conduct, condition or ground.

The commissioner shall serve notice of any hearing required by this article upon the person, stating the time and place therefor, and the conduct, condition or ground upon which the commissioner would make his order. The hearing shall occur not less than 20 nor more than 30 days after notice is served upon the person.
(Added by Stats. 1965, Ch. 1579.)

1065.2. (a) Whenever it appears to the commissioner that any conduct, condition or ground set forth in Section 1065.1 exists, and that irreparable loss and injury to the property and business of a person specified in Section 1010 has occurred or may occur unless the commissioner acts immediately, the commissioner may, without notice, and before hearing, issue and cause to be served upon such person an order requiring such person to forthwith cease and

desist from engaging further in the acts, practices or transactions which are causing such conduct, condition or ground to exist.

(b) At the same time an order is served pursuant to subdivision (a) of this section, the commissioner shall issue and also serve upon the person a notice of hearing to be held at a time and place fixed therein which shall not be less than 20 or more than 30 days after the service thereof. The notice shall contain a statement of the conduct, condition or ground which the commissioner deems violative of the provisions of Section 1065.1.

(c) At any time prior to the commencement of a hearing as provided in Section 1065.1 or subdivision (b) of this section, the person may waive the hearing and have judicial review of the order by means of any remedy afforded by law without first exhausting administrative remedies or procedures.

(Added by Stats. 1965, Ch. 1579.)

1065.3. If, after hearing as provided by Section 1065.1 or subdivision (b) of Section 1065.2, any of the statements as to conduct, conditions or grounds in the notice are found to be true, the commissioner shall make such order or orders as may be reasonably necessary to correct, eliminate or remedy such conduct, conditions or grounds.

(Added by Stats. 1965, Ch. 1579.)

1065.4. Any person subject to an order or proceeding pursuant to this article shall be entitled to judicial review of the order or proceeding by means of any remedy afforded by law. Proceedings for judicial review shall be commenced within 60 days from the making and service of any order issued pursuant to Sections 1065.1 or 1065.3.

(Added by Stats. 1965, Ch. 1579.)

1065.5. If any person violates or fails to comply with any order of the commissioner or any part thereof which as to such person has become final and is still in effect, the commissioner may, after a hearing, notice of which shall be given in accordance with the provisions of Section 1065.1, at which it is determined that a violation of such order has been committed, further order that:

(a) Such person shall forfeit and pay to the State of California a sum not to exceed one hundred dollars ($100) per day for each and every day that such violation or failure to comply shall continue, but in no event to exceed a maximum amount of five thousand dollars ($5,000). Such liability shall be enforced in an action brought in any court of competent jurisdiction by the commissioner in the name of the people of the State of California; and that

(b) Proceedings be commenced to revoke or suspend any license or certificate of authority held by such person under this code, in accordance with the procedures provided therefor.

(Added by Stats. 1965, Ch. 1579.)

1065.6. The powers vested in the commissioner by this article shall be additional to any and all other powers and remedies vested in the commissioner by law, and nothing herein shall be construed as requiring that the commissioner shall employ the powers conferred herein instead of or as a condition precedent to the exercise of any other power or remedy vested in the commissioner.

(Added by Stats. 1965, Ch. 1579.)

1065.7. Any order or notice of the commissioner hereunder may be served on any person, in the same manner and with the same effect as provided for in civil actions in a superior court of this state.

(Added by Stats. 1965, Ch. 1579.)

TAB 7

so to appear I (or we) hereby consent to any subsequent suspension, revocation, refusal to renew, or denial of such license by the commissioner."

(Repealed and added by Stats. 1959, Ch. 4.)

1660. The stipulation and agreement referred to in Section 1659 shall give jurisdiction over, and shall be binding pursuant to its terms upon, the person executing it.

Service may be made upon the commissioner under the circumstances described in the agreement or stipulation and in the manner as provided in Article 1 (commencing with Section 12919) of Chapter 2 of Division 3.

(Amended by Stats. 1970, Ch. 949.)

1661. Whenever an organization licensed as a life agent, insurance agent, or insurance broker, desires to change, remove, or add to, the natural person or persons who are to transact insurance under authority of its license, it shall immediately file an application with the commissioner for an endorsement changing its license accordingly. The commissioner shall require that the qualifying examination provided by this code be taken by any natural person named by such organization to exercise its agency or brokerage powers who, if he were applying for an individual license, would be required to take and pass the qualifying examination. Such natural person or persons and such organization are in all other respects subject to the provisions of this chapter and the insurance laws.

(Amended by Stats. 1969, Ch. 220.)

Article 5. Bonds

(Article 5 added by Stats. 1959, Ch. 4)

1662. An applicant for a license to act as an insurance broker, or for renewal of such license, shall, as part of his application, file the bond as required by this article, and, if licensed, shall continuously maintain such bond in force. Any such license shall automatically terminate immediately upon there being no bond in force, and the license shall be returned by its lawful custodian to the commissioner for cancellation.

(Amended by Stats. 1972, Ch. 1397.)

1663. Such bond shall be duly executed by an admitted surety insurer, shall be continuous in form, and shall be in favor of the people of the State of California.

(Repealed and added by Stats. 1959, Ch. 4.)

1665. The bond of an insurance broker shall be in the amount of five thousand dollars ($5,000). The bond shall be contingent on the accounting by the broker to any person requesting the broker to obtain insurance, for moneys or premiums collected by the broker for insurance other than life.

(Amended by Stats. 1982, Ch. 517.)

Article 6. License Qualifications

(Article 6 added by Stats. 1959, Ch. 4)

1666. Upon the filing of an application for a license in accordance with Article 4 of this chapter, the commissioner may make such investigation and require the filing of such supplementary documents, affidavits and statements as may be necessary to obtain a full disclosure of such information as will aid him in determining whether the prerequisites for the license have been met. If the applicant makes a showing satisfactory to the commissioner that he meets all such prerequisites, the commissioner, if the applicant be eligible therefor, may issue a

certificate of convenience, and upon the applicant meeting any applicable examination requirements may issue a permanent license.

(Repealed and added by Stats. 1959, Ch. 4.)

1667. Except as provided in Section 1669, a license shall not be denied without an opportunity to the applicant to be heard in support of his application. When a hearing is held, the proceedings shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 1959, Ch. 4.)

1668. The commissioner may deny an application for any license issued pursuant to this chapter if:

(a) The applicant is not properly qualified to perform the duties of a person holding the license applied for;

(b) The granting of the license will be against public interest;

(c) The applicant does not intend actively and in good faith to carry on as a business with the general public the transactions which would be permitted by the issuance of the license applied for;

(d) The applicant is not of good business reputation;

(e) The applicant is lacking in integrity;

(f) The applicant has been refused a professional, occupational or vocational license or had such a license suspended or revoked by any licensing authority for reasons that should preclude the granting of the license applied for;

(g) The applicant seeks the license for the purpose of avoiding or preventing the operation or enforcement of the insurance laws of this state;

(h) The applicant has knowingly or willfully made a misstatement in an application to the commissioner for a license, or in a document filed in support of such an application, or has made a false statement in testimony given under oath before the commissioner or any other person acting in his stead;

(i) The applicant has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner;

(j) The applicant has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with him to the danger of loss;

(k) The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract;

(*l*) The applicant has failed to perform a duty expressly enjoined upon him by a provision of this code or has committed an act expressly forbidden by such a provision;

(m) The applicant has been convicted of:

(1) A felony;

(2) A misdemeanor denounced by this code or other laws regulating insurance; or

(3) A public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in acceptance, custody or payment of money or property;

(n) The applicant has aided or abetted any person in an act or omission which would constitute grounds for the suspension, revocation or refusal of a license or certificate issued under this code to the person aided or abetted;

(o) The applicant has permitted any person in his employ to violate any provision of this code; or

(p) The applicant has violated any provision of law relating to conduct of business which could lawfully be done only under authority conferred by such license.

A judgment, plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.
(Amended by Stats. 1965, Ch. 227.)

1669. The commissioner may, without hearing, deny an application if the applicant has:
(a) Committed a felony as shown by a final judgment of conviction thereof;
(b) Committed a misdemeanor denounced by this code or by other laws regulating insurance as shown by a final judgment of conviction thereof;
(c) Had a previous application for a license denied for cause within five years before the filing of the application to be acted upon; or
(d) Had a previously issued license suspended or revoked for cause within five years before the filing of the application to be acted upon.
A judgment of conviction within the meaning of this section includes a judgment following a plea of nolo contendere.
(Amended by Stats. 1965, Ch. 227.)

1670. If an applicant for any license under this chapter, within one year from the date of the receipt by the commissioner of the application, whether or not the filing is complete, or within one year from the date of the issuance to him of a certificate of convenience, if any, whichever is the later date, neither fully qualifies for and receives such license on a permanent basis, nor is denied its issue, such application is automatically denied without prejudice to the filing of a new application for such license unless in a proceeding under a statement of issues the commissioner for good cause determines such denial should be set aside or stayed. Nothing in this section shall nullify Section 1695 to extend the expiration date of a certificate of convenience.
(Amended by Stats. 1980, Ch. 247.)

1671. It shall be conclusively presumed that an applicant does not intend actively and in good faith to carry on the business of (1) a fire and casualty licensee if the license is sought primarily for the purpose of transacting personal or controlled insurance as defined in Section 760, or (2) a life licensee if the license is sought primarily for the purpose of transacting personal or controlled insurance as defined in Section 760.5.
(Repealed and added by Stats. 1959, Ch. 4.)

1672. The commissioner may deny an application filed by an organization, unless both the organization and all natural persons named thereon meet the qualifications for the license for which such application is filed, but the qualifying examination shall be administered only to natural persons. In case the application is for more than one natural person to be named thereon and at least one, but not all, of such persons satisfy the examination requirement, the commissioner may issue such license omitting therefrom the names of the person or persons who fail to satisfy the examination requirement.
(Repealed and added by Stats. 1959, Ch. 4.)

1673. A person licensed as an insurance agent, a life and disability agent, or a disability only agent, may be authorized to transact disability insurance on behalf of any insurer which is authorized to transact disability insurance by the filing of a notice of appointment for that purpose. The authority to transact disability insurance given to an agent by an insurer by appointment shall be effective as of the date the notice of appointment is signed by the insurer. Such authority to transact shall apply to transactions occurring after that date and for the purpose of determining the insurer's liability for acts of appointed agents. The commissioner shall prescribe the forms of such notice of appointment.
(Amended by Stats. 1980, Ch. 360.)

Article 7. License Qualification Examinations

(Article 7 added by Stats. 1959, Ch. 4)

1675. Except as provided in Section 1680, the following applicants who have theretofore been licensed under this code are exempt from the requirements of this article:

(a) An applicant for a license to act as an insurance broker who has been licensed as an insurance broker or surplus line broker during any part of the license year in which the application is filed or the immediately preceding license year;

(b) An applicant for a license to act as an insurance agent or insurance solicitor who has been licensed as an insurance broker, surplus line broker, insurance agent or insurance solicitor during any part of the license year in which the application is filed or the immediately preceding license year;

(c) An applicant for a license to act as a life only agent who has been licensed to transact life insurance during any part of the license year in which the application is filed or the immediately preceding license year;

(d) An applicant for a license to act as a life and disability agent who has been licensed to transact life insurance and all types of disability insurance during any part of the license year in which the application is filed or the immediately preceding license year;

(e) An applicant for a license to act as a disability only agent who has been licensed to transact all types of disability insurance during any part of the license year in which the application is filed or the immediately preceding license year;

(f) An applicant for a license to act as travel insurance agent;

(g) An applicant specifically exempted from the particular qualifying examination requirement by other provisions of this code.

(Amended by Stats. 1969, Ch. 981.)

1676. Except as set forth in Sections 1675 and 1679, the commissioner shall not issue a permanent license pursuant to this chapter to an applicant therefor unless such applicant has within the 12-month period next preceding the date of issue of the license taken and passed the qualifying examination for such license.

(Amended by Stats. 1961, Ch. 290.)

1677. Every qualifying examination for a license under this chapter shall be in writing and shall be of sufficient scope to satisfy the commissioner that the applicant has sufficient knowledge of and is reasonably familiar with the insurance laws of this State and with the provisions, terms and conditions of the insurance which may be transacted pursuant to the license sought, and has a general and fair understanding of the obligations and duties of the holder of such license.

(Repealed and added by Stats. 1959, Ch. 4.)

1678. The commissioner shall, at least once each month, give in each of the cities in which he has an office qualifying examinations under this chapter. He may give such examinations at more frequent intervals or in other places throughout the State.

(Repealed and added by Stats. 1959, Ch. 4.)

1679. A nonresident applicant for a license shall be subject to the same qualifying examination as is required of a resident applicant. Such examination may be administered to an eligible nonresident applicant through the insurance authority of the state or province of Canada of his residence; provided, however, that the commissioner may, in his discretion, enter into a reciprocal arrangement with the officer having supervision of the insurance business in any other state or province of Canada whose qualification standards for the applicant to be examined are substantially the same as or in excess of those of this State, to accept, in lieu of the examination of an applicant residing therein, a certificate of such officer to

TAB 8

Memorandum

To : Bud Specht
Sacramento Office

Date: April 25, 1983

From : Department of Insurance
100 Van Ness Ave., San Francisco, CA 94102
- Paul H. Geary

Subject: ERISA Act

The January 1983 amendments to the ERISA Law may have caused some confusion as to which entities must obtain a Certificate of Authority from the Insurance Commissioner before doing business in this State. I believe it must be kept in mind that the limited exception to the otherwise complete pre-emption of state regulation by the ERISA Law does not provide that all uninsured or partially insured ERISA Plans must obtain a Certificate of Authority from the State Insurance Commissioner. Therefore, before we bring any legal proceeding on the theory that the entity does not have a Certificate of Authority from the California Insurance Commissioner, we must first ascertain that the entity is not within the definition of an employee welfare benefit plan set out in the federal ERISA Law. Of course, if the entity does not qualify as a federal ERISA employee welfare benefit plan, then it does need a Certificate of Authority before it may do business in this State. However, I wish to emphasize, that the mere failure to be fully insured or the failure to obtain a Certificate of Authority are not per se grounds for 1065 orders or injunctive actions.

There is nothing in the ERISA Law which requires a bona fide ERISA Plan to obtain a Certificate of Authority from the State Insurance Commissioner. The amendments to the ERISA Law have subjected bona fide ERISA Plans to state laws which provide "standards, requiring the maintenance of specified levels of reserves and specified levels of contribution, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due." As to plans which are not fully insured there is an extremely ambiguous reference to the application of other state laws which regulate insurance and which are not

inconsistent with the ERISA Law. Certainly, requiring a Certificate of Authority before doing business would be inconsistent with the ERISA Law. As stated, it is only those self-insured or partially-insured plans which do not qualify as bona fide ERISA Plans which may be enjoined on account of their failure to obtain a Certificate of Authority.

The ERISA Law provides that an employee benefit plan means a plan established or maintained by an employer or by an employee organization, or by both for the purpose of providing for its participants or their beneficiaries medical, surgical, or hospital care or benefits. The 1983 amendment added another category known as a multiple employer welfare arrangement which is defined as an employee welfare benefit plan "or other arrangement" for the purpose of offering or providing health and welfare benefits to "employees of one or more employers (including one or more self-employed individuals). It is clear that the new category of multiple employer welfare arrangement by including within the definition single individuals has taken away one factor which heretofore took a plan outside of the ERISA pre-emption. However, other circumstance may be found which would take a plan outside of the ERISA pre-emption. Those factors are stated in the decision of Bell v. Employee Security Benefit Association. to be the following:

1) The employee benefit plan concept envisioned by Congress was to be non-commercial in nature and did not involve solicitation.

2) Congress did not intend to allow companies motivated by profit to escape insurance regulation by setting up a program that is an employee benefit plan in name only. A program set up by a third party entrepreneur rather than by an employer or pre-existing employee group such as a union, having profit making opportunities for marketing agencies and providers of administrative services, with substantial ties to the organizer of the program, was insurance subject to state regulation and not an employee benefit plan under ERISA.

3) Employers must have a voice in management of the trust.

4) Employees must participate in the plan created for the purpose of dealing with employers concerning an employee benefit plan.

-3-

5) The 1983 amendment to the ERISA Law may have eliminated the prior requisite of "commonality" of interest among the members, since it now allows individually self-employed persons to be part of the multiple-employer arrangement. This amendment may impact on the prior requirement that membership had to be limited to one employer, one industry or one union, and that the plan could not be available to virtually anyone who was employed. We will not be sure of this until there is further judicial interpretation.

It appears that the requirement for employer participation and that the plan must be established by an employer or employee ortganization, and cannot be an entrepreneurial organization still apply. Similarly, the employer and employee participants must have a voice in the management of the plan and subscribing employers must be given control over the management and operation of the trust. Taggert Corp. v. E. S. R. O. S., 475 F. Supp. 124 (1979).

PAUL M. GEARY

PMG:ams

Paystaff of California, Inc. - File LA 12972-AP

This file was referred to Compliance Bureau as a possible illegal MET. I have carefully reviewed the file and find no sufficient basis to consider Paystaff to be a multiple employer trust. All of their documents, contracts, and literature, are designed to make it clear that Paystaff is the employer of the persons whose services they contract to clients. All of the benefits to the employees are accordingly to employees of Paystaff. 'Paystaff is in effect a labor contractor who furnishes employees, and is also responsible for the multitude of government regulations and reporting requirements which are imposed on employers.

To find that this was a multiple employer trust, we would have to determine that the employees were actually the employees of the clients rather than the employees of Paystaff. To find that we would have to somehow pierce the carefully established contractual arrangement which Paystaff presents. I doubt that we could get off the ground in such an undertaking and do not see any reason why we should attempt to do so. The file rather strongly shows that Paystaff is set up as the employer who provides the benefits, principally through insurance contracts, and through an ERISA Pension Plan, but which also self-funds to a considerable extent the medical benefits offered to its employees. It is my opinion that Paystaff is intended to be and is apparently set up as a single employer for a legitimate business purpose. As such, the self-funded medical benefits are within the Federal pre-emption of state law and do not come within the limited exception to the otherwise complete pre-emption of the Erlenborn-Burton Bill provided for METs.

PAUL N. GRAY

PNG:ams

TAB 13

MEMO TO: Senator Alan Robbins, Chairman
Senate Insurance, Claims and Corporations Committee

Assemblyman Alister McAlister, Chairman
Assembly Finance Insurance Committee

DATE: December 31, 1984

FROM: Bruce Bunner
Insurance Commissioner

SUBJECT: Report on the Effectiveness of the Enforcement of Insurance Code Section 740

INTRODUCTION

This is the second annual report on the effectiveness of the Department of Insurance enforcement activities in regard to abuses by illegal insurers acting under the guise of the Employees Retirement Income Security Act of 1974.

This report is particularly directed at enforcement of Insurance Code Section 740, which took effect September 7, 1982. This second annual report is called for by a 1983 Assembly Bill, No. 160, Section 3. This Bill took effect as an urgency statute on September 14, 1983. This is the last report called for by the Assembly Bill in question.

ENFORCEMENT STRATEGY

The Department's strategy in 1984 was very similar to the successful strategy of the preceding year.

We continued visibly moving against leading illegal operators, and concentrated on maintaining a high level of cooperation within the industry and regulatory community affected by this problem.

Our program benefited significantly from improved coordination with the industry and the formalization of our cooperative relationship with the Department of Corporation's Enforcement Unit.

The Department's concern with Preferred Provider organizations was considerable in 1984. We devoted significant effort to gathering information on operators and activities in this area.

The following is a list of the essential elements of the Department's strategy in 1984. Many of these objectives carried over from 1983.

(1) Issue stop orders against at least two major promoters based on cases completed in 1984. In regard to these, gain public notice through press releases and media contact, particularly through trade journals.

(2) Identify all possible self-funded MET operators, and all possible insured MET operators, organize this information and maintain and update it as a long term intelligence base.

(3) Maintain and distribute lists in accordance with the provisions of Section 740.

(4) Establish contacts within the insurers and administrators in the industry, to give us cooperation and ongoing information for the lists.

(5) Prepare investigative assignments on all possible perpetrators identified via (3) and (4), and conduct preliminary field interviews of each. These are to be followed by full scale investigations of all apparent self-funded METs.

(6) Where self-funded METs are identified and evidence is to be assembled, use the Department of Insurance's normal investigative and enforcement powers to put the illegal MET operators out of business.

(7) Concentrate on bringing about compliance as soon as possible on the part of the self-funded MET industry leaders.

(8) Develop and prosecute disciplinary and, where applicable, criminal cases against illegal MET operators.

(9) Maintain open lines of communication for use by the public and agents to obtain information regarding MET practices.

(10) Maintain our cooperative relationship with the Department of Corporations and Department of Labor at the working levels, to enhance our intelligence regarding the Multiple Employer Trust problem and our enforcement of Insurance Code Section 740. This is to be accomplished in part by formal exchanges of information in regularly scheduled meetings with the Department of Corporations.

(11) Maintain existing information sources in the public and industry and develop new ones. This also will assist us in keeping track of the illegal MET operators and monitoring their reaction to our enforcement effort.

(12) Closely watch the preferred and exclusive provider organization fields for serious abuses, particularly for the entry of known illegal MET operators to this field.

(13) Monitor all new administrator applicants to determine ownership and business connections. This will enable us to limit the entry of persons known to have previously operated illegal Multiple Employer Trusts into the legitimate insurance business, where insurers could be victimized.

ENFORCEMENT ACTION

Investigations

During 1984, Department investigators completed 132 investigations regarding administrators and trusts. Most of the investigations were based on information that the entity may have been acting illegally as a self-funded insurer. At this writing, 89 investigations are in progress.

Of the 1984 closed investigations, 20 resulted in informal corrective action and warnings for non-serious law violations found in field investigation. 13 were referred to Department of Insurance attorneys to begin regulatory action regarding serious violations of law. These 13 are discussed under Stop Orders, Disciplinary Actions and Criminal Actions below.

Stop Orders

The Department of Insurance issued two stop orders in 1984 regarding 740 violations. These were issued against Insurance Data Administrators and Totalcare International, Inc. Both organizations were clearly acting illegally as insurers and were endangering the California citizens who subscribed to their health coverages.

Investigative reports have been completed on three other illegal organizations. These reports are in the hands of Department attorneys, with the expectation that stop orders will shortly be issued.

Disciplinary Actions

Disciplinary actions were taken against the operators of American Benefit Association, Martin Levine and Lee Parry. The licenses of both individuals were revoked following administrative hearing. It is expected that these above respondents will seek to overturn the license revocations through mandate proceedings.

Reports detailing violations of law by five other individual and corporate licensees were submitted to Department's hearing attorneys. It is expected that disciplinary actions will be begun soon on each of the above.

It is noteworthy that, again in 1984, we found that most operators of illegal METs do not possess Department of Insurance licenses.

Criminal Actions

One case was reported on in 1983 as under review by two District Attorneys pending possible criminal action. This case was ultimately rejected by both District Attorneys, principally because of the complex nature of the evidence and the limited resources available to these District Attorneys to prosecute. It was expected that extensive time would be required for the prosecution of the case.

In 1984, however, all three principals of Totalcare International, Inc. were arrested based on a case presented to the Riverside District Attorney regarding the operation of an illegal insurer. This operation was revealed by a joint Department of Insurance and Department of Corporations investigation. The individuals are expected to tried for crimes involving both operating an unlicensed insurer illegally and diverting monies from it.

Several other cases currently under investigation show a high likelihood of criminal conduct endangering California citizens. These cases will, if the evidence bears out be referred to District Attorneys for possible criminal prosecution.

1983 Contested Cases

Two cases were reported in 1983 as being hotly contested. One Multiple Employer Trust had resisted our efforts to secure its records and had failed to honor a Department of Insurance subpoena. At the end of 1983, consideration was being given to taking the matter to Superior Court for enforcement of the subpoena. Following

review by Department's attorneys, it was determined that further information was needed to move the matter to Superior Court. During the course of investigation, it has been determinated that the Multiple Employer Trust involved ceased its activity around the time our subpoena was originally issued.

The other hotly contested case involved a Multiple Employer Trust which the Department was seeking to place under conservation. This trust had in turn sued the Department of Insurance in federal court to resist our effort to assert jurisdiction. The federal court has determined to hear the case. At this time the Department of Insurance is enjoined from acting on our conservatorship application in state court. Both the jurisdiction and solvency issues will be tried in June, 1985.

Lists

The required lists, under Insurance Code Section 740, have been published each month in 1984 and maintained in each Department of Insurance office. All are readily available to the public upon request. It is estimated that 50 sets were requested by the public and issued during 1984. The network of supporting lists and information reported in 1983 still exists. In fact, the Department of Insurance's project team has made these lists more comprehensive and accurate through improved records screening and as a result of the cooperation with the industry and Department of Corporations.

Interagency Cooperation

The working level of cooperation noted in last year's report continued through 1984. Frequent exchanges of information occurred within the ranks of Department of Insurance, Department of Corporations and Department of Labor. This cooperation resulted particularly in a good effort on the Totalcare case which was handled successfully through a joint effort.

Written lead information was exchanged all year by Department of Insurance and Corporations. Additionally, at the initiation of Department of Insurance Supervising Insurance Investigator James Harrington, a quarterly series of meetings is underway. The first meeting occurred in early November 1984, with Enforcement personnel present on both sides and exchanging leads, case status information, as well as planning joint strategies and discussing investigative techniques and the legal environment of the trust problem.

Cooperation between the Department of Insurance and the U. S. Department of Labor had been in abeyance early in the year due to a Department of Labor reorganization. This reorganization is still underway, however, working level cooperation has been reinstituted, with regular monthly contacts now occurring.

The State of Texas Department of Insurance, Division of Unauthorized Insurers requested a three day orientation from the California Department on our handling of the MET problem. This was requested because (1) California Department of Insurance has a good reputation for effective handling of the MET problem and (2) a "740-like" bill was at the time pending in the Texas legislature. The three day orientation was given to the Texas personnel, and was found to have been very helpful to them.

It prompted a Texas suggestion, later repeated by other states, that meetings be held annually among representatives of the states where the problem is most serious. This would promote enforcement and limit the ability of perpetrators to freely move from state to state with their operations. It would also even out the differences in strategies nationwide and give the states a better ability to meet this problem uniformly and economically.

Preferred Provider Organizations/Exclusive Provider Organization

Based on our initial experiences with PPOs and EPOs, there was concern that the illegal MET operators might move into this area as the MET possibilities dried up. Our industry sources had indicated that this was under consideration by some of the least reputable of those operators.

We devoted substantial resources to this situation in the first half of 1984. After an early spate of activity, the operators found difficulty in setting up cash flows that could be diverted. As a result, the feared trends did not develop.

Only normal regulatory problems exist with PPOs and EPOs at this time. The bulk of these revolve around the technicalities of affiliating a PPO with an insurer, and uncertainty in the minds of all involved, particularly the public, about the PPO's role in insurance coverage.

It is possible that the Department's early response to the potential problem discouraged the MET promoters from moving into the area.

THE EFFECT OF THE DEPARTMENT OF INSURANCE ENFORCEMENT PROGRAM ON THE MET PROBLEM IN 1984

Following the criteria considered in our previous report, we maintained our control of the problem as established in 1983. At this point, there appears to be very little activity that does not quickly come to our attention. Meetings and conversations with other regulators and those in the industry indicate that California has established a good reputation for effective action against the METs. This is confirmed by comments from certain illegal promoters that have been related back to the Department indicating that California is not considered a prime area for such abuses at this time. Various entrepreneurs are known to have said that illegal METs in California are no longer feasible, and that the possibilities have dried up.

My staff and I have become convinced that the seriousness and longevity of the MET abuses has been due, in the main, to the existence of underlying problems.

Two market conditions have primarily caused employers to accept the coverage of such unstable and illegal organizations.

Firstly, these trusts generally market their products at a price far below that offered to small employers by the regular group insurers. This has been the case since the beginning of this proolem in 1976. There have been many efforts past and current by insurers to reduce the cost of their health coverages to the small employer. To our knowledge, these have not succeeded to date.

The healtn coverage portion of ERISA was apparently intended in part to offer a federal solution to the cost of health insurance.

In recent times, the extremely negative loss experience of some insurers has led to a companion problem for these small employers. Many insurers will simply not offer health policies to them.

Promoters are attempting through illegal plans to offer poor quality coverage to these employers who are completely unable to locate health insurance that they or their employees can afford.

The second market factor involved is the willingness of some employers to accept poor quality health coverage for their employees. It is clear that some employers, unconcerned with the welfare of their employees, will agree to the cheapest alternative they are offered, regardless of the nature, or quality of the benefits offered, or the financial stability of the organization giving the coverage.

It is clear that an issue of public policy is involved, regarding the welfare of responsible small employers and their employees. Many Californians receive their only chance at comprehensive health coverage through their employer. Employees who can't get good quality health insurance from their employer generally cannot buy policies that will make their health care affordable.

I believe that it is important for the Legislature and the Department of Insurance to work together to impose a solution and offer specific guidelines to address the underlying problems of health insurance for the small employers.

BRUCE BUNNER
Insurance Commissioner

BB:mn

MEMO TO: Senator Alan Robbins, Chairman
Senate Insurance, Claims and Corporation Committee

Assemblyman Alister McAlister, Chairman
Assembly Finance and Insurance Committee

DATE: December 27, 1983

FROM: Bruce Bunner
Insurance Commissioner

SUBJECT: Report on the Effectiveness of the Enforcement of Insurance Code Section 740

INTRODUCTION

The abuses in the employee health coverage field, and the enforcement problems associated with the Employees Retirement Income Security Act of 1974 are well known to you both.

This report addresses the effectiveness of enforcement in the Multiple Employer Trust area following passage of Insurance Code Section 740, which took effect September 7, 1982. The enforcement atmosphere was also affected by the passage of amendments to ERISA, in the form of the Erlenborn bill, which took effect in January, 1983. These two law changes were enacted to give insurance regulators a legal basis to assert proper jurisdiction over health insurers operating in California.

This report is called for by the provisions of Assembly Bill 160, Section 3, which took effect as an urgency statute on September 14, 1983. Further reports are to be filed annually, on or before January 1, until 1985.

ENFORCEMENT STRATEGY

The Department of Insurance developed a strategy for enforcing the provisions of Insurance Code Section 740, following its 1982 enactment.

As no positions were allocated to the Department of Insurance to assist in enforcement, the reallocation of resources from other investigative priorities was the only workable option. It was necessary to minimize the detrimental effect on our overall investigative program. Our enforcement strategy therefore relied most of all on identifying those acting in this area, and on visibly moving against leading illegal MET operators. We also planned efforts to gain the cooperation of those operating legitimately in the industry, and those in regulatory community.

Following is a list of the essential elements of the strategy the Department developed in the latter part of 1982.

(1) Complete our regulatory action regarding American Benefits Trust, in cooperation with the Department of Corporations. This case was actually developed in 1981 and 1982.

(2) Issue stop orders against at least two major perpetrators by early 1983. In regard to these stop orders, gain public notice through press releases and media contact, particularly in the trade journals.

(3) Identify all possible self-funded MET operators, and all possible insured MET operators, organize this information and maintain and update it as a long term intelligence base.

(4) Maintain and distribute lists in accordance with the provisions of Section 740.

(5) Establish contacts within the insurers and administrators in the industry, to give us cooperation and ongoing information for the lists.

(6) Prepare investigative assignments on all possible perpetrators identified via (4) and (5), and conduct preliminary field interviews of each. These are to be followed by full scale investigations of all apparent self-funded METs.

(7) Where self-funded METs are identified and evidence is to be assembled, use the Department of Insurance's normal investigative and enforcement powers to put the illegal MET operators out of business.

(8) Concentrate on bringing about compliance as soon as possible on the part of the self-funded MET industry leaders.

(9) Develop and prosecute disciplinary and, where applicable, criminal cases against illegal MET operators.

(10) Maintain open lines of communication for use by the public and agents to obtain information regarding MET practices.

(11) Develop and sustain a cooperative working relationship with the Department of Corporations, to enhance enforcement of Insurance Code Section 740, and all related insurance laws.

(12) Utilize information sources in the industry, and monitor changes in it, to stay abreast of the reactions of the MET operators to our enforcement activities. Particularly, we are interested in whether or not they move on to other areas or other types of health plans.

IMPLEMENTATION

The Department of Insurance participated with the Department of Corporations in placing American Benefits Trust in receivership in 1982. Our investigative staff expended extensive time looking into the activities of the ABT principals in 1982 and 1983. We were credited by the receiver with obtaining over $1 million for the claimants,

In early 1983, stop orders were issued which forced two prominent self-funded METs to cease operating. As a result of the stop orders, 5 related self-funded METs under the control of one of these operators also terminated their activities. We followed our stop orders with press releases and received significant favorable publicity, particularly in the trade journals. As a direct result of these orders, 7 plans were terminated and wound up. A great deal of investigator time has gone into monitoring the wind up of the 7 plans.

In early 1983, we conducted a complete record review to identify possible MET operators. We additionally made a mass mailing to the industry requesting information as to their knowledge of those operating in this area. As a result of the information we obtained, between January and November of 1983, 154 investigations of possible illegal Multiple Employer Trusts were begun. 78 have been completed. As of 12/9/83, 123 such investigations were still progressing. The bulk of the completed investigations revealed no illegal activities. Mostly, these investigations found administrators dealing individually with single employers self-funded health plans as permitted by ERISA. Among these still pending investigations, however, several cases are coming to completion this month which will be recommended to our attorneys for stop order action.

In certain investigations, furthermore, we met some resistance. We found that our ability to assert our normal investigative and enforcement measures has significantly increased. In large part this is as a result of the understanding within the industry that 740 gives us the authority to investigate Multiple Employer Trusts.

Among the pending investigations will be found the following:

(1) Several cases showing criminal activity by self-funded MET operators. One multiple case is being reviewed by two District Attorneys, another is at the search warrant stage, and three more are in the late stages of investigations which, it is believed, will lead to our recommending prosecution to District Attorneys.

(2) We've used stopped orders, subpoenas and other normal investigative procedures with some success.

(3) We are meeting considerable resistance in two cases. In one, we subpoenaed records of a self-funded Multiple Employer Trust. Our subpoena was not honored, and we are now at the stage where we will move in Superior Court to enforce it. In the other case, our conservation/liquidation action against an acknowledged industry leader is being hotly contested. In that case, we have been enjoined by a U. S. District Court Judge from pursuing our conservation/ liquidation action. We expect that Insurance Code Section 740 will be legally tested in that court. It is believed that the statute will be tested in the courts.

(4) Disciplinary cases are expected early next year on two licensees of the Department of Insurance who are involved in illegal METs. It should be noted that insurance licenses are not generally held by self-funded operators.

Our system of lists, set up to satisfy the requirements of 740, was put in place in April, 1983. It was revised and approved in September, 1983. The lists are available to the public and to producers upon request, and some have been sent out, although the requests have been less than expected so far. The public lists are supported by a system of pending case lists within the Department of Insurance, which are used to keep Department personnel informed on MET activities. This assists us in obtaining intelligence information from the industry through all Department of Insurance contacts.

The cooperative relationship developed between Insurance and Corporations is particularly good at the working level, so that joint action has been taken in the past year were advantageous, and so that enforcement of the law and the protection of public welfare is enhanced. Information is exchanged between the two organizations on an appropriate basis, and we have supported each other in several cases of joint interest.

Our enforcement objectives have largerly been met. The development of disciplinary and prosecutable cases however has been slowed by a lack of personnel. We received no additional personnel to enforce 740, and there have been numerous frozen investigative and clerical vacancies in the Enforcement Division. These vacancies have prevented us from sufficiently reallocating resources within our Investigation Bureau. The result is unavoidable investigative delays. These delays will slow, but not stop our enforcement efforts.

THE EFFECT OF THE ENFORCEMENT PROGRAM ON THE MET PROBLEM IN 1983

In the absence of a legal reporting requirement for self-funded METs, we can only deduce what effect we have had. All indications are that in 1983, the enforcement program succeeded in establishing control of the self-funded MET problem, but not eliminating it.

Numerous entities were identified and investigated for the first time last year. Only one large Multiple Employer Trust (of the dimensions seen in recent years) exists today. That Multiple Employer Trust was set up in 1975. It has been involved continuously since 1978 in legal action with the federal government. That Multiple Employer Trust was sued by the Department of Insurance in a conservation/liquidation action in 1983, and litigation is being vigorously pursued.

The large majority of administrators and associations that we investigated last year as possible self-funded METs turned out to be operating legally. Many of these entities pointed out that the problem has abated to some extent.

The known entrepreneurs in the Multiple Employer Trust area were monitored. Their activities are slowing in the self-funded MET area and are cropping up more and more in other areas. For example, one group whose trust we closed down has been seeking to operate only in other states, but not in California, for a year's time. An effort to begin operating here is expected, however we have intelligence information that our enforcement activity is of great concern to this group, and is preventing them from successfully recruiting agents and marketing.

Other entrepreneurs have advised us directly that they are going to stay out of self-funding in the future. Still others are seen trying their hand at other types of abuses - but not within the safe haven of the broad ERISA exemption. Examples of the illegal activity included preying on financially troubled insurers; preying on preferred provider organizations; moving into federally regulated union type programs. Abuses will still occur from these people, but in areas of clear regulatory control.

Of course, not all entrepreneurs and criminals have left this field. A great deal of enforcement work is left to be done. In this, the 1983 amendments to 740, coupled with the effect of the Erlenborn bill and a continuation of our enforcement strategy should further curtail the abuses. If 740 is judicially overturned however, I would expect the MET problem in California to again worsen.

Several investigations will be completed this month that will be recommended to Department attorneys for stop order or conservation, liquidation action. This will provide a solid beginning for our enforcement program in 1984.

In concluding, it should be recognized that the people who are victims of illegal MET schemes are, in the final analysis, also victims of larger

problems. They are victimized by high health care costs, reverse competition in the employer health plan area and the historical lack of federal enforcement of its own pre-emptive act, the Employees Retirement Security Income Act of 1974.

BRUCE BUNNER
Insurance Commissioner

JPH:mn

bcc: Roxani Gillespie
Brian Walkup
Bud Specht
Dennis C. Ward
James P. Harrington, Jr.
Don Blackey
Marcelino Cudiamat
L. A. MET Group
S. F. MET Group

Memorandum

To : David Ikeda, Chairperson
Charles Wiscavage
Douglas Buske
Herbert Riggs
Milton White

Date : 3/26/80

From : Department of Insurance
100 Van Ness Ave., San Francisco, CA 94102

James P. Harrington, Jr.

Subject: ERISA MET Task Force

The purpose of this memorandum is to formalize the organization and structure of this investigative task force, as approved by the Chief Investigator. This has been a loosely formed operational unit over the past 3 years.

David Ikeda will be guiding the operations of this Task Force from day to day.

The Task Force will have responsibility for the following identified areas:

1. Intelligence - identifying, gathering and retaining in a usable fashion all data on California Multiple Employer Trusts which are purportedly functioning as ERISA Plans.

2. Complaints - responding in the most meaningful way possible to complaints, directing complainants to agencies with appropriate or possible jurisdiction, retaining complaints in the intelligence filing system for reference.

3. Investigation - quick, effective response to specific multiple employer trust assignments as they are given to either individual investigators or groups of investigators. These investigations may cover specific features of an organization, as well as the usual general operational review.

4. Reporting - maintaining and issuing a periodic multiple employer trust status report for the Department's use; reporting on investigations and intelligence as circumstances require, for the use of this Department, the Department of Labor, the California Attorney General or

Memo To: David Ikeda, Chairperson
Charles Wiscavage
Douglas Buske
Herbert Riggs
Milton White
From: James P. Harrington, Jr.
Subject: ERISA MET Task Force
Date: 3/26/80

other interested entities. Note that our report will typically cover investigations which are governed by our confidentiality rules.

5. Development and Exchange of Information and Solutions - through communication, periodic meetings and listening to and analyzing input from others, assisting each other in dealing with specific problems and in developing good solutions to problems that arise.

Our first task force meeting will be held in April in Los Angeles on a date and time to be established. An agenda will be published in advance. Included in the agenda now planned will be a background discussion by the undersigned of the problem, discussion of the goals and objectives of the Task Force, assignment of duties to Task Force Members and a general discussion of the problem and possible approaches and solutions to it.

Effective March 13, 1980, the bulk of the task force records have been transferred from the San Francisco office to our Los Angeles office, where they are now maintained under the direction of David Ikeda. Should any of you have any questions or problems arise before the first task force meeting, please contact him.

JAMES P. HARRINGTON, JR.

JPH:mn

Copies to: Edward L. Middelton
F. D. Hubert

James P. Harrington, Jr.
Supervising Investigator

October 28, 1982

Dennis C. Ward
Chief Investigator

MET Task Force

The enactment of AB 2670 (C.I.C. Section 740) and the formation of the Department's MET Committee will have a significant impact on the Investigation Bureau's MET Task Force. Specifically, the MET Task Force must be prepared to respond to:

1. An increased demand for investigative resources to identify, examine and monitor MET'S, as mandated by AB 2670;

2. an increased demand for supervisory/administrative control over the activities of the MET Task Force to insure prompt, effective and accurate identification and investigation of illegal MET'S; and

3. an increased demand for coordination and communication with other divisions in the Department and the MET Committee.

To meet these demands, we must assess, and alter as necessary, the structure, staffing and scope of the MET Task Force. In this regard, I am appointing you as the Project Manager of the MET Task Force. As the project manager, you will be responsible for planning, organizing, staffing, directing and coordinating the efforts of the MET Task Force.

To provide you with adequate supervisory/administrative support on this project, I am appointing Marcelino Cudiamat as the Project Supervisor for the MET Task Force. Marcelino will report directly to you on matters relating to the MET Task Force and will be responsible for case control and daily operations of the MET Task Force.

Initially, I would like to staff the MET Task Force with the following Associate Insurance Investigators:

1. Herb Riggs
2. Jan Neumert
3. John Noonan
4. Charles Wiscavage
5. Chris Packer

Each of these individuals has experience in the MET area and is fully capable of conducting and leading investigations of MET'S on an independent basis. Furthermore, as Associate Insurance Investigators, each of these individuals has access to additional investigative resources through the people assigned to them under our lead system.

Once you have had an opportunity to review and assess the MET situation, you may wish to add investigative resources and/or clerical resources to the Task Force. Please keep me apprised of any changes you wish to make in this area.

When assessing the structure and staffing of the MET Task Force, please keep in mind the following objectives of the MET Task Force:

1. To provide a pool of experienced investigators to promptly and effectively identify and investigate illegal MET'S;

2. to provide an organizational structure within the Investigation Bureau to monitor the activities of MET'S and to respond to MET inquiries received from other members of the Department and the public at large; and

3. to coordinate and communicate with the Department's MET Committee to insure a smooth and uniform enforcement of MET'S as mandated under AB 2670.

Please provide me with your assessment of the MET situation and a plan of operation for this Task Force by December 1, 1982.

DENNIS C. WARD
Chief Investigator

DCW:mj

cc: Bud Specht, Paul M. Harvey, Marcelino Cudiamat, Don Blackey
John Petkovich, and Milt White

Bud Specht March 30, 1983

Multiple Employer Trust Task Force

The purpose of this memorandum is to summarize for you the operating plan of the Investigation Bureau Task Force on this very serious problem. Various plans are being proposed within the Department, principally because in 1982 two pieces of legislation were enacted, one State and one Federal, that are intended to change the legal climate in which Multiple Employer Trusts operate.

In 1974, the federal government passed the Employees Retirement Income Security Act of 1974 (ERISA). This Act encouraged single employers, employer associations and employee associations to establish indemnity health plans under their own supervision. Such entities would issue indemnity contracts to employees or members similar to health insurance policies. State laws would normally require such an indemnitor to obtain a Certificate of Authority. ERISA dealt with this problem by specifically prohibiting application of the State Insurance Codes to such plans.

In 1974, pricing and affordability problems in the health insurance industry, and particularly the insolvency of Old Republic Life Insurance Company, made employee health insurance almost unavailable to numerous small businesses. Entrepreneurs, some well intentioned and some predatory responded to the unavailability by forming and marketing purported ERISA health plans. These health plans were predominantly set up on a cash basis, rather than legal reserve. Most failed to comply with the flat requirement in ERISA that plans be set up or maintained by the employers, or employee groups.

In summary, numerous entrepreneurs began to operate insurers on a cash basis without qualifying the insurers under the Financial and Certificate of Authority requirements of this State and others.

Some of these plans were entirely fraudulent. Many more were entrepreneurial and bankrupted or failed. The California insurance buying public has by now been victimized to the tune of tens or millions of dollars of unrecoverable unpaid claims and unearned premiums.

This Department has consistently taken the position, since 1976, that any health insurance arrangement that does not qualify under ERISA, or Knox-Keene, should obtain a Certificate of Authority in the usual way in order to operate in this State. The position and requirement have been difficult to enforce. The legal mechanisms available to the Department permit us to order an illegal insurer to cease operating. The legal uncertainties resulting from the preemption seriously impairs our law enforcement. The legal suits filed often dragged on for years, while in the meantime the entrepreneurs had closed the trust we were suing against and opened a new one of the same description.

Following passage of Insurance Code Section 740 (In McAlister's Assembly Bill 2670) and passage of the Ehrlenborn Bill, the Multiple Employer Trust Task Force was instructed to enforce the requirement that any provider of health coverage that is not licensed or officially recognized in writing as regulated by some governmental body, is an insurer. As such, these are subject to the Certificate of Authority requirements, financial requirements and full scope of the California Insurance Code. This is based on both the Ehrlenborn Bill and the Insurance Code Section 740.

We have made a mailing which is designed to identify all trusts operating in California, have prepared lists for the McAlister Committee and internal use identifying 133 known operating and defunct trusts, and 69 investigation subjects who may be self-funded multiple employer trusts. We have put together and disseminated the list required by Insurance Code Section 740 of unregulated entities. We have issued and prepared for issuance orders against several significant offenders. We have directed significant efforts at taking criminal action where it appears that provable case of fraud against the public or the trust can be put together. We have

active investigations in progress on all 63 possible violators. Several investigators and a supervisor have devoted enormous quantities of time to this regulatory effort since 1976.

It is my firm belief that the Department must not in any way appear to recognize the legitimacy of these self-funded trusts. Virtually all we have examined in the past have had no legal justification for offering indemnity benefits. The Department of Labor has long ago taken the position that virtually no Multiple Employer Trust can qualify for an ERISA exemption from the provisions of State Insurance Codes. For the Department to require financial reporting, or otherwise legitimize these trusts may impair in our ability to regulate them through Insurance Code Section 700, which requires insurers to possess a Certificate of Authority prior to operating here.

The Department's regulatory plan for Multiple Employer Trusts that are self-funding should be: (1) identify such trusts; (2) determine if each is operating legally, through a license or written Department of Labor opinion; and if not, (3) issue Cease and Desist Orders, or Conservation/Liquidation Orders under the powers given to the commissioner in the Insurance Code. This is not a theoretical plan. It has been done successfully in this State and others.

JAMES P. HARRINGTON, JR.
Supervising Investigator

JPH:mn

cc: Dennis C. Ward
Marcelino Cudiamat
Paul M. Harvey
John Montgomery

740 I.C. ACTIVE MET LIST - PUBLIC 9-4-84

(The following trusts are considered to be active in California. The following are entities listed pursuant to the requirements of California Insurance Code Section 740. This list is prepared and published according to law without liability of any kind to the State of California or its employees.)

ADAPSO Group Insurance Benefit Trust

Aetna Insurance Trust

Agri-Business Group Insurance Trust

Alliance Group Medical Trust

Allied Businessmen's Association, Inc.

Allied Group Insurance Trust (AGIT)

Amalgamated Meatcutters & Butcher Workmen Welfare Plan (AMC & BW Trust)

American Baptist Association Employees Insurance Trust

American Business Group Trust

American Business Insurance Trust

American Businessmen's Group Insurance Trust

American Commerce Trust

American Commercial Trust

American Consumer Insurance Trust

American Consumers Trade Association

American Federation for Labor & Business Insured Trust

American Federation of Musicians Group Insurance Trust

American Group Agency

American Healthcare Trust (The)

6992a

American Hereford Association Group Insurance Trust

American Independent Businessman's Group Insurance Trust

American Legion Auxiliary Insurance Trust

American Medical Insurance Group Insurance Trust

American National Trust Services

American Subcontractors Assoc. Insurance Trust

American States Special Employer Trust

American United Life Triangle of Protection Insurance Trusts

American Veterans Group Insurance Trust

Associated Bldg. Industry of No. California Insurance Plan

Associated Companies Health Benefit Plan and Trust

Association Professional Liability Insurance Plan (APLI) (The)

Babcock Employers Group Insurance Trust

Bank Credit Card Group Insurance Trust

Bankers Life Nebraska Preferred Trust

Bay Area Builders Insurance Plan

Beneficial Employees Security Trust (BEST)

Beneficial Employees Security Trust of Utah

Benefits Trust for Employers

B.E.S.T. - Beneficial Employees Security Trust

Builders Insurance Trust

Building Employers Trust

Business & Professional Trust

Cal Builders Insurance Trust

Cal/Group Trust

California Agricultural Employers Group Insurance Trust

California Dentists' and Employees Health Trust

California Development Maintenance Association Trust

California Employers Group Insurance Trust

California Grape & Tree Fruit Insurance Trust

California Health Maintenance Association

California Hotel and Restaurant Trust

California Livestock Growers Assoc.

California Real Estate Employers-Employees Group Insurance Trust

Calsak Employees Benefit Plan

Capitol Series Group Insurance Trust

Central Life Insured Employers National Trust (CLIENT)

Central Valley Agricultural Employees Trust

Christian Employees Association

Christian Medical Association

Christian Medical Program (CEMP)

Christian Organizations Medical Society (COMS)

Christian School Insurance and Pension Trust

Citrus Insurance Trust

CMSA (California Moving & Storage Association) Group Benefit Trust

Colonial Textile Service Group Benefit Plan and Trust

Commercial Employee Benefit Assoc. (CEBA)

Commercial and Industrial Benefit Trust-Convalescent Hospital

Commercial and Industrial Benefit Trust-Manufacturing Industries

Commercial and Industrial Benefit Trust-Retail Industries

Commercial and Industries Benefit Trust-Service Industries

Commercial and Industries Benefit Trust-Wholesale Industries

Commercial Life Insurance Company Group Trust

Commercial Sales & Service Trust

CommuniCARE

Communicating for Agriculature, Inc.

Comprehensive Health Plans, a private Health Care Trust

Consolidated Group Trust

Construction Trust

Continental Association of Resolute Employers (C.A.R.E.)

Contract Construction Consolidated Group Trust

Cooperative of American Physicians, Inc./Mutual Protection Trust

Cypress School District Employee Benefit Trust

Dunne and Bradstreet Trusts

Educational and Athletics Benefit Assn. (The)

Electronics Association of California

Empire Trust

Employee Benefit Planning Association Trust

Employee Plan Services

Employer-Employee Insurance Trust

Employers Group Health Trust

Executive Medical Trust

Falcon Plan Trust

Famex Industry Trust

Farm Bureau Farmworkers Life and Health Trust Fund

Farmers Rice Cooperative Trust Fund

Finance, Insurance and Real Estate Consolidated Group Trust

Finance Trust

Financial Industries Reserve Service Trust (F.I.R.S.T.)

First Alliance Multiple Employers Trust

501 Trust

Food Products Distributors Trust

Foothill Administrators Trust

Foresight Employers Trust

Foundation for Medical Care

Free Enterprise Trust

Fresno Unified School District Vision Plan

Furniture Industry Benefit Trust

General Employees Trust Fund

Government Employees Affiliated Dental Insurance Trust

Government Trust

GRL Panel Providers

GRL Trust

Greater Missouri Financial Institutions Trust

Group Regional Insurance Trust

Guardent

Harmans Employee Benefit Trust

Health Care Benefits Trust

Health Care Benefits Trust Fund

Health Maintenance Assoc., Inc.

Health & Welfare Trust Fund
Machinists Union, Los Angeles

Hotel and Restaurant Trust

Independent Automotive Service Association Insurance Fund

Independent Employers Trust Fund II

Independent Industries Group Insurance Trust

Independent Industries Trust

Independent Man's Equity Program

Independent Operators Association

Insurance and Prepaid Benefits Trust

Insurance Benefit Plans Health & Welfare Fund

Insurance Brokers and Agents Group Insurance Trust

International Trust

Junipero Serra Health & Accident Trust of Salinas Valley Independent Growers Association

Legal Service Nationwide Employee Benefits Organization, Inc. (NEBO)

MD Group Health Plan

Mare Island Naval Shipyard Association Dental Plan

MED-200

MMI Trust (The)

Manufacturing Industry Consolidated Group Trust

Manufacturing Trust

Medical Eye Services of California, Inc.

Medical Professional Trust

Medical Staff Associates Group Insurance Trust

Mini Group Employer's Trust

Mini-Maxi Plan Group Health Program (The)

Morefar Employers Trust

Multiple Benefit Trust

Multiple Organization Services Trust

Multiple Security Program Insurance Trust (MSP)

Multiple Unit Security Trust (M.U.S.T.)

National Association for the Self-Employed

National Association of Independent Contractors, Inc. (NAIC)

National Association of Temporary and Technical Employees (N.A.T.T.E.)

National Automobile Dealers Insurance Trust

National Automotive Insurance Trust

National Business Insurance Trust

National Collegiate Insurance Trust

National Dental Service

National Employers Group Insurance Trust

National Employers Security Trust (NEST)

National Florist Insurance Trust

National Health Insurance Trust (Dental Plan)

National Professional and Trade Association Insurance Trust

National Publishers Insurance Trust

National School Employees Insurance Trust

National Senior Citizens Group Insurance Trust

Northern California Musicians Association Trust

Northwest Employers Insurance Trust

Oil Marketers Industrial Trust

OMNI Trust (The)

Optical Employers Association of Northern California

Orange Foundation

Pacific Admiralty Trust

Pacific Allied Insurance Trust

Pacific Southwest Association of Small Employer Firms

PAY-MED

Pay Med Trust

Peninsula Manufacturers Association Insurance Plan

Peoples Dental Plan

Plan (The)

Planned Benefit Trust

Plastics Manufacturers Association

Policyholder's Employers Trust (P.E.T.)

Preferred Risk Insurance Trust

Printing Industries of Northern California Employee Benefit Trust (PINC)

Printing Industries Association, Inc. of Southern California Employee Benefit Trust (PIASC)

Professional & Executive Insurance Trust

Professional Group Insurance Trust

Professional's Benefit Trust

Professionals Group Insurance Trust

PRO-MED '80s

Promedex

PRO-USA Medical Benefit Trust

Realtors Group Dental Plan

Related Benefits Medical Trust

Religious Trust (RETA)

Restaurant and Tavern Health Fund

Retail Trade Consolidated Group Trust

Retail Trust

Rhode Island Hospital Trust National Bank

Riverside County Foundation for Medical Care

Sacramento Independent Hotel, Restaurant & Tavern Employees Trust (SHRTE)

San Joaquin Employers Insurance Trust (SJET)

San Joaquin Foundation for Medical Care

Scotsman Benefit Trust

Scripps League Newspapers, Inc. Medical-Dental Plan

Scripps League Newspapers, Inc. Life Insurance Plan

Senior Citizens of American Group Insurance Trust

Service Industry Consolidated Group Trust

Service Industry Insurance Trust

Service Trust

Shin Nihonjin Kai Benefits Trust

Small Business Benefit Plan

Small Business Discount Association

Small Business Health Plan

Small Business Independent Trades Association

Southern California Drug Benefit Fund

Southern California Drywall, Decorating and Painting Trades Trust

Southern Counties Grocers Trust Employee Benefit Trust

Southern Health Benefit Plan

Southwest Administrators

Southwest Medical and Employee Benefit Trust

Special Market and Risks Trust (S.M.A.R.T.)

Three-Nine Trust (T.N.T.)

3/33 Group Benefit Trust

Tire Dealers Industrial Trust

Transportation, Communication and Public Utility Consolidated Group Trust

Transportation Trust

Trustee of the Foresight Employers Trust

ULTRACARE

United Agricultural Employee Welfare Benefit Plan & Trust

United American Industries Trust (UAIT)

United Association Trust (Formerly American Business Insurance Trust, Presidents Trust)

United Benefits Employees Trust (U-BET)

United Business Benefits Trust

United Federation of Small Business Trust

United Senior Citizens Group Insurance Trust

Universal Assurance Trust

Valley Employers Trust

Valley Teamsters Benefit Trust

Vanguard Group Dental Plan Trust

Veterans Association Benefit Program

WEB Service Co. Employee Medical Benefit Plan

West Multiple Employers Trust (WestMET)

Western Benefit Plan Admin. Employees Benefit Trust

Western Employee Security Trusts

Western Employers and Employees Security Trust

Western Growers Insurance Trust

Western Pacific Employers Trust

Western States Advertising Industries Group Insurance Trust Fund

Western States Electronic & Light Manufacturing Trust

Western States Financial & Clerical Trust

Western States Trades & Services Trust

Western Teamsters Welfare Trust

Western Unity Association

Wholesale Trade Consolidated Group Trust

Wholesale Trust

Worker's Trust

World Management Association

Worldwide Businessmans Assoc.

740 I.C. INACTIVE MET LIST - PUBLIC 9-4-84

(The following Trusts are considered to be inactive in California. The following are entities listed pursuant to the requirements of California Insurance Code Section 740. This list is published according to law without liability of any kind to the State of California or its employees)

AID Fringe Benefits Group Trust

Accumulated Coverage Trust

American Association of The Healing Arts

American Benefits Limited Trust

American Businessmen's Association

American Business Conference Employer Benefit Association

American Consumer Assoc.

American Employee Association

American Employee Benefit Association

American Employers Group Insurance Trust

American Federation For Labor & Business Employer Benefit Trust

American Federation of Business

American Health Association Benefit Trust

American Health Systems Trust

American Indian Trust

American Institute of the Healing Arts

American Personnel and Guidance Association

American Salesmen's Association

American Trade Association

Builders Exchange Trust (Part of American Salesmen's Assoc.)

Business Insurance Trust

California Business Group Trust

6006a

740 I. C. INACTIVE MET LIST - PUBLIC

California Service Planning Trust

Central Employee Benefit Association

Citizens Health Plan (bankrupt license Knox & Keene)

Common Market Employee Benefit Association

Consolidated Union Employee Trust

Consumer's Association for Medical Protection (C.A.M.P.)

Continental Employee Benefit Association

Continental Organization of Medical, Professional and Technical Employees Trust (COMPETE)

Corporate Financial Services Employer - Employee Trust

Corporate Services for Insurance, Inc.

Dent-All Corporation of America

Employee Security Benefit Association

Employees Indemnity Trust

Employer-Employee Benefit Trust

Federal Employee Benefit Association

Financial Benefit Insurance Trust

First Federation Trust

First Foundation Trust

First Fund Trust

Group Health Plan Trust

Group Health Services

Health Care Industries Trust

Hospital Welfare Association Trust

Industries Multi Protection and Care Plan

Insurance Benefit Plans H-W Fund

Interstate Protective Association

Magna Carta Trust

Manufacturers & Distributors Association Trust

Marketing Administrators Trust

Medical Expense Reimbursement Insured Trust

Ministers Benefit Trust

Mutual Employers Trust

Mutual Medical Employee Benefit Association

National American Businessmen's Association

National Association of Barbers & Cosmetologists

National Benefit Association

National Business and Professional Employers Trust

National Business Conference Employee Benefit Association - (Calif.)

National Business Conference Employee Benefit Association - (Wash.)

National Employee Benefit Association

National Employers Health Association - (N.E.H.A.)

National Foundation for Health Care

National Health Benefit Plan

National Independent Employees Association - Self Funded 3-22-82
(dba Employees Dental Care Program)

National Multiple Employers Foundation Trust

National Self-Funded Plans, Inc.

National Trades Association - Formerly The New World Maintenance Organization - OOB 5/83

New World Maintenance Association, Inc.

Northwest Association of Independent Businesses

Northwest Federation of Independent Businesses, Inc.

Pacific Insurance Administrators

Pacific Security Benefit Plan

Pacific Security Health Plan

Preferred Employee Benefit Association

Professional Services Buyer's Association, Inc.

Protective Benefit Association Plan

Presidents Trust (The)

Resident Apartment Managers Association

Retail Wholesale Service Trades Trust

Security Health Plan (bankrupt license Knox & Keene)

Security Multiple Employers Trust

Southern Health Benefit Foundation

Southern Health Benefit Plan

Southland Union Medical Trust

Stop Loss Voluntary Employees Beneficiary Association

Transwestern Employer-Employee Benefit Association

TRICAR

United Benefit Association

United Health and Retirement Association

United Service Employee Benefit Association

Universal Benefit Trust

Viable Insurance Plan Insurance Trust; AKA: VIP Trust

Voluntary Employees and Dependents Association Trust

Western Businessmen's Association Trust

TAB 19

HEALTH LAWYERS
NEWS REPORT

PUBLISHED BY NATIONAL HEALTH LAWYERS ASSOCIATION
[illegible] Street N.W. Suite 20 Washington D.C. 20006 202/833-1100

Vol. 13, No. 2 LIB February 1985

PPO ANTITRUST GUIDELINES: Paul McGrath, Assistant Attorney General of the Antitrust Division of the U.S. Department of Justice, addressed "an area of enormous potential significance to the growth of competition in health care markets - contracting for the provision of services through PPOs and other alternative delivery groups," at NHLA's Antitrust Program, held in Washington, D.C. Jan. 22. He said he wished, "to dispel the uncertainty that may inhibit the development of pro-competitive arrangements of this kind, and to warn against certain anticompetitive types of concerted behavior which would thwart the growth of that competition."

In general, McGrath said, "it seems clear that PPOs controlled by insurance companies, third party administrators, or independent contractors have real pro-competitive potential and pose little risk of anti-competitive harm." Moreover, he said, "although PPOs created and controlled by providers present somewhat more of an antitrust risk and thus are subject to somewhat greater scrutiny, the Antitrust Division recognizes that they, too, generally provide significant competitive benefits." Indeed, according to McGrath, provider initiative and entrepreneurship are exactly what is needed to inject competition into the marketplace.

McGrath favors removing, or at least significantly reducing regulatory barriers to the formation of competitive PPOs, particularly unnecessarily restrictive free choice statutes that prohibit groups of physicians and hospitals from selectively negotiating with health care plans. He also favors open dissemination of information concerning health care providers and utilization patterns. "Access to such information is both essential to third party payers purchasing PPO services and to those seeking to gather PPO panels made up of cost conscious providers," McGrath stated. This was the reason that the Justice Department encouraged HHS to make public data profiles collected by peer review organizations serving specific hospitals and physicians, he said.

McGrath outlined Antitrust Division's general approach to analyzing provider sponsored PPOs which uses principles similar to those applicable to joint ventures. He said that the provider controlled PPO must show that it is not a simple naked price-fixing restraint, and that the horizontal aspect of its operation, the agreement between the physicians setting price and utilization standards, is reasonably related and ancillary to the new productive joint venture. "Where the

PPO can make the showing that it offers economic integration and efficiency advantages and that those advantages outweigh potential harm from lessening competition from participating providers, it should pass antitrust muster," McGrath said.

Some aspects of PPO agreements which McGrath said would militate in favor of concluding that an efficiency enhancing integration is present, included an agreement to treat patients on a fee-for-service basis at reduced or discounted levels or pursuant to some fee schedule with no balance billing; an agreement to abide by some limitation on the practices of the physicians in the form of utilization review; an agreement to administer claims and jointly market the venture; and an agreement to select a group of limited size to engage in bidding for contracts against other panels.

In short, McGrath said "a PPO of limited size can make a plausible showing that it is an integrated activity enhancing efficiency and competition and that price and other horizontal aspects of its operation are both necessary and ancillary to those activities."

McGrath said that PPOs need not be overly concerned about excluding physicians and hospitals as participants. "The essential feature of a PPO is its selectivity and the primary competitive risks associated with PPO formation ... are of overinclusiveness rather than exclusion. Thus, a PPO panel must be limited and the exclusion of some interested physicians for the pro-competitive ends of competition among panels is a necessary part of the process," he said.

However, McGrath said that mergers that reduce options for competitive contracting, anticompetitive restrictions on nonphysician providers, and regulatory constraints on provider responses to changes in competitive conditions will be scrutinized closely.

In the context of joint research and development, McGrath indicated that combinations of competitors with 20% or less of the market would not likely raise competitive problems, and that levels somewhat above the general merger standard applicable to concentrated industries would be applicable to provider joint ventures. He said that the Antitrust Division would probably not challenge the size of a PPO where it appeared that the market could support five equally sized competing PPOs, and that the Division would apply a market-specific analysis to each case.

The Division, he said, would look closely to evidence of anticompetitive intent, and to any collateral arrangements which bear no relationship to the PPO's success and which pose a competitive problem. "Any attempt to influence the prices charged by participating doctors and hospitals to payers outside their contracting panel will raise antitrust questions," he said. Likewise, he said, "efforts to inhibit the freedom of providers to associate with other health care plans or to discourage providers from granting similar or greater price concessions to other PPOs will be closely

examined. In short, consistent with conventional analysis of ancillary restraints, the PPO agreement must be no broader than necessary to promote the legitimate purpose of the venture," McGrath concluded.

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FINAL HMO REGS ANNOUNCED BY HHS: The Department of Health & Human Services' final regulations authorizing prospective payment for eligible health maintenance organizations and competitive medical plans were published in the January 10, 1985 Federal Register. Government officials expect that the regulations, which permit the payment of 95 percent of the average Medicare cost per patient in the HMO's service area, will increase enrollment in HMOs by 200,000 this year. Each of the 150 HMOs participating in Medicare is expected to have increased enrollment averages to 5% to 10%, and fee-for-service physicians could lose about 3% of their Medicare patients.

The regulations became effective February 1, 1985. They provide HMOs, preferred provider organizations, and other alternative delivery groups with two payment options. They may continue to be paid under cost based-reimbursement methodology or they may opt for the new system, under which they will be paid a prospective monthly fee for each Medicare beneficiary. Under the latter option, Medicare will pay HMOs the 95 percent in advance, with the 5 percent difference representing what federal health officials said would be a savings to the Government from the expected Medicare outlay. It is expected that the HMO's cost of service, including profit, will ordinarily be less than the 95 percent paid by Medicare. Therefore, HMOs will be able to return the difference either in reduced charges or expanded services. HMOs will be able to offer services, such as dental care, prescription drugs, or eyeglasses, which are not normally covered by Medicare.

"Under these rules, HMO's can offer Medicare beneficiaries substantial benefits not covered by Medicare," said Secretary of Health & Human Services, Margaret M. Heckler.

The final regulations differ from those initially proposed in that they require HMOs and the other alternative delivery plans to be subject to Medicare's peer review system for both inpatient and outpatient treatment. HHS' decision to require peer review has drawn criticism from the HMO industry. Robert C. Burnett, MD, past president of the California Medical Association, said he thinks that there is an "enormous conflict of interest" when a peer review organization, which in many cases does the majority of its business in so-called "private review" for self-insured companies, also must review an HMO, the competitor to the PRO's other clients. However, Wayne Fowler, director of the Health Care Financing Administration's division on group health plan operations, said, "We're aware of the industry's concerns not to let the fox guard the hen house." Therefore, the government intends to make sure that physicians reviewing care be familiar with prepaid plans.

TAB

licensed to transact variable annuity contracts in another state or commonwealth during any part of the license year in which the application is filed or the immediately preceding license year.

(Amended by Stats. 1974, Ch. 544.)

1758.4. Except as may otherwise be provided in this article, a license as a variable contract agent shall be applied for, issued, and renewed in the same manner and for the same terms as a life and disability agent's or life only agent's license.

(Amended by Stats. 1973, Ch. 332.)

1758.5. The commissioner may, pursuant to Chapter 4.5 (commencing with Section 11371), Part 1, Division 3, Title 2 of the Government Code, adopt reasonable rules and regulations necessary for the convenient administration of this article.

(Added by Stats. 1967, Ch. 1707.)

CHAPTER 5A. ADMINISTRATORS

(Chapter 5A added by Stats. 1977, Ch. 998)

1759. For purposes of this chapter, "administrator" means any person who collects charges or premiums from, or who adjusts or settles claims on, residents of this state in connection with life or health insurance coverage or annuities other than any of the following:

(a) An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of that employer.

(b) A union on behalf of its members.

(c) An insurance company which is either licensed in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business or prepaid hospital or health care service plan (including their sales representatives licensed in this state when engaged in the performance of their duties as such).

(d) A life or health agent or broker licensed in this state, whose activities are limited exclusively to the sale of insurance.

(e) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(f) A trust, its trustees, agents, and employees acting thereunder, established in conformity with 29 U.S.C. 186.

(g) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code, its trustees, and employees acting thereunder, or a custodian, its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code.

(h) A bank, credit union or other financial institution which is subject to supervision or examination by federal or state regulatory authorities.

(i) A company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided the company does not adjust or settle claims.

(j) A person who adjusts or settles claims in the normal course of his or her practice or employment as an attorney at law, and who does not collect charges or premiums in connection with life or health insurance coverage or annuities.

(k) An adjuster licensed by the Insurance Commissioner when engaged in the performance of his or her duties as such.

(*l*) A nonprofit agricultural association.

(Amended by Stats. 1983, Ch. 101.)

1759.1. No administrator shall act as such without a written agreement between the administrator and the insurer, and such written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and five years thereafter. Such written agreement shall contain provisions which include the requirements of Sections 1759.2 to 1759.8, inclusive, except insofar as those requirements do not apply to the functions performed by the administrator.

Where a policy is issued to a trustee or trustees, a copy of the trust agreement and any amendments thereto shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the insurer and the administrator for the duration of the policy and five years thereafter.

(Added by Stats. 1977, Ch. 998.)

1759.2. Whenever an insurer utilizes the services of an administrator under the terms of a written contract as required in Section 1759.1, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured shall be deemed to have been received by the insurer, and the payment of return premiums or claims by the insurer to the administrator shall not be deemed payment to the insured or claimant until such payments are received by the insured or claimant. Nothing herein shall limit any right of the insurer against the administrator resulting from its failure to make payments to the insurer, insureds or claimants.

(Added by Stats. 1977, Ch. 998.)

1759.3. Every administrator shall maintain at its principal administrative office for the duration of the written agreement referred to in Section 1759.1 and five years thereafter adequate books and records of all transactions between it, insurers and insured persons. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The insurer shall retain the right to continuing access to such books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator on the proprietary rights of the parties in such books and records.

The commissioner shall have access to such books and records for the purpose of examination, audit, and inspection. Any information contained therein, including but not limited to the identity and addresses of policyholders and certificateholders, shall be confidential, except the commissioner may use such information in any proceedings instituted against the administrator.

(Added by Stats. 1977, Ch. 998.)

1759.4. An administrator may use only such advertising pertaining to the business underwritten by an insurer as has been approved by such insurer in advance of its use.

(Added by Stats. 1977, Ch. 998.)

1759.5. The agreement shall make provision with respect to the underwriting or other standards pertaining to the business underwritten by such insurer.

(Added by Stats. 1977, Ch. 998.)

1759.6. All insurance charges or premiums collected by an administrator on behalf of or for an insurer or insurers, and return premiums received from such insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled thereto, or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator. If charges or premiums so deposited have been collected on behalf of or for more than one insurer, the administrator shall keep records clearly recording the deposits in and withdrawals from such account on

behalf of or for each insurer. The administrator shall keep copies of all such records and, upon request of an insurer, shall furnish such insurer with copies of such records pertaining to deposits and withdrawals on behalf of or for such insurer. The administrator shall not pay any claim on behalf of or for such insurer by withdrawals from such fiduciary account. Withdrawals from such account shall be made, as provided in the written agreement between the administrator and the insurer, for (1) remittance to an insurer entitled thereto; (2) deposit in an account maintained in the name of such insurer; (3) transfer to and deposit in a claims paying account, with claims on behalf of or for such insurer to be paid as provided in Section 1759.7; (4) payment to a group policyholder for remittance to the insurer entitled thereto; (5) payment to the administrator of its commission, fees or charges; or (6) remittance of return premiums to the person or persons entitled thereto.

(Amended by Stats. 1978, Ch. 280.)

1759.7. All claims paid by the administrator from funds collected on behalf of the insurer shall be paid only on checks or drafts of and as authorized by such insurer.

(Added by Stats. 1977, Ch. 998.)

1759.8. With respect to any policies where an administrator adjusts or settles claims, the compensation to the administrator with regard to such policies shall in no way be contingent on claim experience.

(Added by Stats. 1977, Ch. 998.)

1759.9. Where the services of an administrator are utilized, the administrator shall provide a written notice approved by the insurer, to insured individuals, advising them of the identity of and relationship among the administrator, the policyholder and the insurer. Where an administrator collects funds, it must identify and state separately in writing to the person paying to the administrator any charge or premium for insurance coverage the amount of any such charge or premium specified by the insurer for such insurance coverage.

(Added by Stats. 1977, Ch. 998.)

1759.10. No person shall act as, or hold himself out to be, an administrator in this state, other than an adjuster licensed in this state for the kinds of business for which he is acting as an administrator, unless he holds a certificate of registration as an administrator issued by the commissioner. Such certificate shall be issued, renewed, and held in accordance with, and subject to, all the provisions applicable to a life agent contained in Articles 6 (commencing with Section 1666), excluding Sections 1672 and 1673, 10 (commencing with Section 1708), excluding Section 1714, 11 (commencing with Section 1716), and 13 (commencing with Section 1737), excluding Sections 1741 and 1745, of, and subject to the fees applicable to resident life agents as set forth in Article 14 (commencing with Section 1750) of, Chapter 5 of this division. Every administrator shall also comply with Section 1724.5.

(Amended by Stats. 1981, Ch. 348.)

CHAPTER 6. SURPLUS LINE BROKERS

(Chapter 6 enacted by Stats. 1935, Ch. 145)

1760. Any citizen of this State may negotiate and effect insurance on his own property with any nonadmitted insurer.

(Enacted by Stats. 1935, Ch. 145.)

STATE OF CALIFORNIA—BUSINESS AND TRANSPORTATION AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF CORPORATIONS
OFFICE OF THE COMMISSIONER
600 S. COMMONWEALTH AVENUE
LOS ANGELES, CALIFORNIA 90005
(213) 736-2741

IN REPLY REFER TO:

FILE NO. _____ _____

March 13, 1985

Honorable Alister McAlister
Member of the Assembly
State Capitol, Room 3112
Sacramento, CA 95814

Dear Mr. McAlister:

This is my response to Sal Bianco's letter to Commissioner Bunner and me of October 4, 1984, which contained "a series of policy issue questions on the subject of overlapping jurisdiction" by our respective departments in the area of health care coverage. Your letter of December 13, 1984, states that a specific request for complete answers to Mr. Bianco's questions was made in our meeting with you on October 15, 1984. It is my understanding that the October 15th meeting was for the purpose of relieving the Departments of Corporations and Insurance of the burden of responding in writing to each point in Mr. Bianco's October 4, 1984, letter.

During our October 15th meeting, a substantial number of points raised in Mr. Bianco's letter were discussed. From the discussion, I believed that you and others were satisfied with the responses given.

It was also agreed that it would be more efficient to schedule a series of meetings focused on specific subject areas contained in Mr. Bianco's October 4th letter. To date, neither Mr. Bianco nor any member of the Assembly Finance and Insurance Committee staff have contacted me to set up such a meeting.

Nevertheless, below, my staff and I have attempted to respond to Mr. Bianco's questions relating to the Department of Corporations and the administration of the Knox-Keene Health Care Service Plan Act of 1975.

1. In our view, what is presently in existence is a dividing line established by a series of laws regulating different types of businesses along functional lines. That is, some businesses providing health care coverage to consumers do so as insurance carriers; others do so as non-profit hospital plans, health care service plans, and health maintenance organizations (the latter being qualified by the federal government and licensed by the state). These businesses offer a series of competing health care products to consumers who are able to make a choice based on price, type of coverage, convenience, accessibility, etc.

Some have argued that an "overlap of jurisdiction" exists in the area of administration of multiple employer trusts. Indeed, some administrators operate simultaneously on behalf of health care service plans, insurers and multiple employer trusts. We are unaware of any person that has structured itself in such a way that both departments believe that each has jurisdiction, however.

2. I believe the Department of Corporations is taking all reasonable administrative steps to effect good coordination in the enforcement of our respective laws. The Insurance Commissioner and I have established a close liaison between the chief investigators of the respective departments and joint investigations have been made of persons whose appropriate licensing status is in doubt. Most of the enforcement activities of our departments relative to unlicensed persons occur in southern California. The Southern California offices of our departments are located at 600 South Commonwealth Avenue, Los Angeles, California. Regular contact between our enforcement personnel is easily accessible and frequent. We have no statutory language to propose because the present combined enforcement activities of the Departments of Corporations and Insurance are desirable.

One may also argue that the jurisdictions of the Departments of Corporations and Insurance coincide to the extent that, for example, a licensed insurer regulated by the Department of Insurance also owns or otherwise controls a licensed health care service plan regulated by the Department of Corporations. This does not, in our opinion, present a problem in itself or danger to the public because these activities are requlated by one department or the other. This functional allocation-type of regulation is no different than the type of regulation presently existing in the area of financial institutions where banks or savings and loan associations wishing to engage in real estate, insurance, or securities businesses either directly or through subsidiaries or affiliates become subject to regulation under various laws. There are in fact other examples of multiple government agency regulation without adverse affect to the public.

3. When questions arise that require consultation between the departments, these consultations are usually in the form of telephone conversations, letters or other informal methods. We do not believe that a rigid statutorily or administratively created procedure is necessary or desirous. There is no formal written policy and periodic meetings have not been routinely scheduled. I believe it is preferable to consult with each other on an "as necessary" basis when issues or questions arise. Additionally, since November 1984, the supervising investigator for the Department of Corporations has scheduled meetings with the supervising investigator for the Department of Insurance to

discuss leads, the level of involvement of each department in joint investigations, and other matters. These informal meetings will be scheduled at least quarterly.

The Department of Corporations works closely with the Department of Health Services with respect to Medi-Cal contracts, pilot program exemptions, medical surveys and financial examinations.

4. We regard AB 1166 as a self-executing mandate from the Legislature that does not require that specific policy or guidelines be established other than compliance with the general statutory directive. Were this not the case, we would not have changed our position on the bill, after negotiation with the author's office, from oppose to neutral. Presently, the Commissioners receive copies of proposed changes to regulations under their respective laws during the public comment period afforded by the Administrative Procedure Act. This has been sufficient in the past and we believe it is sufficient for the future. Additionally, consultations with respect to proposed rule changes prior to noticing the proposed rule for public comment will be handled on an "as necessary" basis informally through the Department of Corporations' Health Care Service Plan Division (and/or Office of Policy) and the Department of Insurance. We believe that a formal, inflexible procedure would greatly add to the already burdensome time constraints on the rule-making process imposed by the Administrative Procedure Act and the Knox-Keene Health Care Service Plan Act of 1975, itself.

5. The Department of Corporations, under the Knox-Keene Health Care Service Plan Act of 1975 has responsibility under Article 5 (specifically, Health and Safety Code Section 1367) to regulate the quality of health care through regulatory standards and medical surveys. The Commissioner has promulgated regulations (10 CAC Secs. 1300.67 through 1300.70; 1300.80; 1300.80.10) which deal with the scope of basic health care services, continuity of care, accessiblity of services, standards for plan organization, subscriber and group contracts, contracts with providers, coordination of benefits, grievance procedures, public policy participation by subscribers and internal quality of care review systems. The Health Care Service Plan Division has in existence a complaint identification and resolution procedure which is also used to monitor quality of care.

Presently, the Department of Corporations has scheduled over 24 medical surveys for the fiscal year ending June 30, 1985. The criteria for the quality of medical care offered by a health care service plan must be at least as high as the standard in the community in which the health care service plan is located.

6. The Knox-Keene Health Care Service Plan Act of 1975 requires that medical quality and financial solvency standards be met on an on-going basis. The law requires that the Commissioner perform medical surveys and financial examinations at least once every five years. If complaints or other information reach the Commissioner with respect to medical quality, accessiblity or availability of health care services or financial solvency, medical surveys or financial examinations may be performed to investigate the claim or allegation. Presently, the Commissioner anticipates that at least twenty-four medical surveys will be completed for the fiscal year ending June 30, 1985. Routine medical surveys and financial examinations are usually separate (because of the difference in the time involved in performing the respective survey or examinations and because medical surveys and financial examinations are performed by different classes of professionals), but could be integrated into one visit.

7. In response to Mr. Bianco's question, we have attached a copy of the Commissioner's Rules and a copy of the application for licensure as a health care service plan (which is also included in the Commissioner's Rules). Reference to the health care service plan application will identify those standards for obtaining a health care service plan license. Also attached are the proposed changes to the application, which have been noticed for public comment as required by the Administrative Procedure Act, but are not yet effective. The Knox-Keene Health Care Service Plan Act of 1975 may be found at Section 1340 et seq. of the Health and Safety Code.

8. Disclosure requirements under the Knox-Keene Health Care Service Plan Act of 1975 are found in Commissioner's Rules 1300.61, 1300.61.3, 1300.63, 1300.63.2, 1300.63.3, 1300.63.50, 1300.64.50 and 1300.64.51, which are attached to this letter. Absent a clear showing of the necessity for additional disclosure, we believe that no additional disclosure is required by administrative regulation or by statute. To our knowledge, there are no facts indicating a necessity at this time.

We do not feel that a "common set of disclosure requirements" should be established for use by the Departments of Corporations and Insurance. Essentially, insurance contracts and health care service plan contracts are unlike products. Such a "common disclosure" requirement would create confusion in the minds of consumers since insurance contracts are contracts of indemnity while health care service plan contracts are contracts for service. Problems with definitions, payment/service obligations, exclusions, etc. would abound. The resulting document may be more confusing than helpful.

9. The Department of Corporations, historically, has sought to challenge the federal law preemption of state law under the Employee Retirement Income Security Act of 1974 ("ERISA"). The Department of Corporations defended its assertion of jurisdiction over private-sector, self-insured individual and multiple employee benefit plans in Hewlett-Packard Co. V Barnes (C.A. 1977) 571 F. F.2d 502; cert. denied 439 U.S. 831. However, the Federal District Court's holding that the Knox-Keene Health Care Service Plan Act of 1975 was preempted as to employee benefit plans as defined in and subject to ERISA was upheld on appeal and the U.S. Supreme Court refused to hear the matter. For several years, the Department of Corporations worked with Senator Alan Cranston's office to secure an amendment to ERISA to allow state regulation. In 1982, the Department of Corporations was asked to assist in the drafting of AJR 107 (Res. Chap. 183; Stats. 1982) which memorialized the U.S. Congress to reconsider the over-broad preemption clause in ERISA in view of the grave problems encountered by state regulators in their efforts to assert jurisdiction over "phoney" ERISA trusts. Subsequent amendments to ERISA now allow for specified, non-conflicting state regulation of certain employee benefit plans.

The following discussion of how an enforcement case is handled under the Knox-Keene Health Care Service Plan Act of 1975 (the "Act") by the Department of Corporations is provided in answer to the remaining questions under Item 9 of Mr. Bianco's October 4th letter. A "formal written opinion" as to whether a person claiming exemption under the Act on the basis of ERISA is not necessary for the bringing of an enforcement action against that person. Essentially, the Department's attorneys and investigators analyze the facts of the case and apply the requirements of the Act. A preliminary conclusion is then reached as to whether the unlicensed person is a health care service plan within the meaning of the Act and, if that person claims ERISA preemption, a letter from the U. S. Department of Labor concluding that the ERISA preemption is available must be produced. If no letter is produced, the Department of Corporations subpoenas the books and records of the person preliminary to taking administrative action. If the unlicensed person fails to produce the books and records the Commissioner sues in Superior Court to enforce the subpoena against that person. It is in the Superior Court where the issue of whether the person has ERISA preemption is decided, typically in the context of the Department of Corporations' efforts to resist removal of the case to Federal District Court.

10. This Item relates to the Department of Insurance.

11. The Department of Corporations does not consider AB 3342 to be necessary or useful in assisting in enforcement actions relating to coordination of benefits. The enforcement of coordination of benefits requirements will proceed independent of AB 3342. The Valley Clerk's Trust Fund is widely acknowledged to be a legitimate ERISA plan. Accordingly, application of the state coordination of benefits provision to it would be preempted by ERISA.

Regarding SB 2024, The Department of Corporations has drafted proposed rules and distributed them for comment to the Health Care Service Plan Advisory Committee as required by the Act. The Advisory Committee objected to having the rules patterned after the Department of Insurance rules, desiring that the Department of Corporations use the new NAIC coordination of benefit rules. SB 2024 requires that the coordination of benefit rules of the Department of Corporations be substantially identical to the Department of Insurance rules. The Department of Insurance has not adopted the new NAIC rules, but applies the new NAIC rules regarding coordination of benefits as a matter of fact. The Advisory Committee's final comment period has concluded; however, at least one person has requested that the Department of Corporations consider withholding the publication of the proposed rules for public comment until the very most recent NAIC changes can be incorporated. Presently, Commissioner's Rule 1300.67.13 deals with coordination of benefits. By request of the Advisory Committee, the Department of Corporations proposes to include the provision in subsection (b)(6) of Rule 1300.67.13 in the new proposed rules to preclude a delay in furnishing any reasonably necessary health care services pursuant to a plan contract when a health care service plan coordinates benefits.

12. The Commissioner has proposed that certain words in Health and Safety Code Section 1346.5 and Insurance Code Section 740 be changed to add greater precision to the intent of AB 160. Two of the suggested changes were made by AB 2347 (Chap. 947, Stats. 1984). The remaining suggested changes have not been made by the author. The Commissioner's AB 160 Report is attached.

13. As you know, the Department of Corporations files quarterly reports as required by AB 160. At present, these reports are current. The Departments of Corporations and Insurance essentially work together in the investigation of consumer complaints and enforcement of the respective laws against those persons claiming an exemption from licensure by virtue of ERSIA. If an unlicensed person is not a health care service plan and cannot produce a letter from the U. S. Department of Labor that ERISA preemption is available, it is referred to the Department of Insurance. Regarding complaints, if a complaint received by the Department of Corporations is determined to relate to insurance

company activities, it is referred to the Department of Insurance. If the complaint reveals that health care service plan activity is involved it is investigated by the Department of Corporations.

14. Mr. Bianco asks us to define the following terms found in Insurance Code Section 740. As you know, the Commissioner of Corporations has no authority to interpret Insurance Code Section 740. Nevertheless, in our opinion, the term "entity" in all likelihood could be defined similar to that of a "person". The term "person" is defined in the Knox-Keene Health Care Service Plan Act of 1975 (as well as various other codes, such as the Corporations Code). The term "entity" is not. The term "entity" is not defined by statute in the Insurance Code.

The terms "services" and "coverage" cannot, in our opinion, be defined synonymously. The term "coverage" has a broader connotation than "services". "Services" connotes a narrower scope of activity while "coverage" could include services.

The term "regulated" could arguably be limited to those entities that are actually licensed under a law. On the other hand, it is possible to argue that the term "regulated" includes those persons who are subject to regulation but are unlicensed either because of an exemption or unlawfully. In our opinion, the term "subject to regulation" is broader.

If the term "providing coverage in this state" contained in Insurance Code Section 740 were changed to "providing services in this state," it is our opinion that Insurance Code Section 740 would be limited in its application.

15. This question asks for the results of enforcements actions under Insurance Code Section 740. The Department of Corporations has no authority to enforce this section of the Insurance Code.

16. As stated previously, the Commissioner of Corporations has no authority to interpret Insurance Code Section 740. Nevertheless, with respect to the term "subject to regulation," we believe the term has a broader connotation than the term "regulated". As set forth previously the term "subject to regulation" arguably includes those persons who are licensed and those who may have a partial exemption from licensure. This term also includes those persons who are unlicensed, but are unlicensed unlawfully. The term "regulated" arguably could be limited to that activity for which a license has been obtained. Thus, the term "regulated" is capable of a narrower interpretation.

It may be logically possible for a person subject to the jurisdiction of the Department of Corporations to be subject to the jurisdiction of the Department of Insurance at the same time.

However, there are no cases or examples of it. Your attention is directed to Health and Safety Code Section 1343(d)(1) which provides that the Knox-Keene Health Care Service Plan Act of 1975 does not apply to a person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the person is providing health care service directly or through contracting health providers. We have no policies or procedures which we have adopted to address this hypothetical of concurrent jurisdiction. We will address the problem when and if a case actually exists.

17. The Commissioner of Corporations has no authority to interpret Insurance Code Sections 740 and 742. We know of no statutory definition of "preferred provider organization". Assembly Bill 2347, other than making technical clean up amendments to the Knox-Keene Health Care Service Plan Act of 1975, added Insurance Code Section 742. The Commissioner of Corporations has no authority to enforce Insurance Code Section 742.

18. Assembly Bill 707 (as amended during the 1983-84 Legislative Session) attempted to create a state and federal exemption from state and federal antitrust laws (which prohibit conspiracies, combinations and contracts in restraint of trade) for the formation of groups and combinations of health care providers and purchasers by allowing combinations for contract negotiations. The bill was overly-broad in that it was not limited to preferred provider and exclusive provider organizations, but applied to <u>any</u> combination formed to create an "efficient size contracting unit" without regard to any affect on competition. Additionally, the bill did not clearly state that it raised a factual evidentuary presumption; rather, the bill stated that is was the Legislature's intent to exempt specified arrangements from state and federal antitrust law. Even if a presumption would have been established by the bill, the result would have made prosecution of conspiracies to fix prices much more difficult or even impossible given that "negotiations" would be exempt from state antitrust laws. It goes without saying that AB 707 would not have had an affect on federal antitrust laws, except for the creation of confusion over the authority of a state to change federal law.

Assembly Bill 707 was unnecessary, moreover, because the state antitrust law when read together with the health care reforms enacted in 1982 clearly indicated an intent not to subject preferred provider or exclusive provider organizations to the state's antitrust laws, especially in the area of Medi-Cal contracts. See Business and Professions Code Section 16725. The proposed exemption could have invited group boycotts, predatory conduct and the exercise of monopoly power by authorizing health care providers and purchasers to engage in these practices as part

of the negotiating process. For example, a group boycott of all doctors and hospitals in a given area by certain insurers or third-party purchasers; conversely, a boycott against some doctors or hospitals by certain insurers or other competing doctors or hospitals.

Rather than facilitating the contracting for Medi-Cal services under the 1982 reform legislation which provided for a special negotiator, initially, and now the California Medi-Cal Assistance Commission as the special negotiator, AB 707 had the potential to allow those contracting with the state to collude for the purpose of fixing fees prior to any negotiations with the state. The bill had the potential to not only harm consumers by limiting the choice and increasing health care costs, but to harm those it purported to aid by giving a false sense of security with respect to an exemption from state and federal antitrust laws. Federal law provides that the state may create an exemption from federal antitrust laws only by clear legislative mandate which compels continuating supervision and regulation of specific anticompetitive conduct. Assembly Bill 707 contained permissive language only and provided for no state supervision and regulation.

19. The Commissioner of Corporations does not regulate preferred provider organizations unless they meet the statutory definition of a health care service plan. We have not seen any statement by the Attorney General of California to the effect that absent regulations preferred provider organizations are not exempt from the state's antitrust law. In fact, Business & Professions Code Section 16725 (the Cartwright Act) provides that reasonable restraints of trade are not prohibited under the state antitrust law. State antitrust law is patterned after the federal antitrust laws. We are also unaware of any contention by the U. S. Department of Justice or Federal Trade Commission that a "pro-competitive" preferred provider organization is exempt from the federal antitrust laws. We are aware, however, that the U. S. Department of Justice will honor requests for opinions from preferred provider organizations on the subject of the applicability of the federal antitrust laws to a proposed plan of business. The U. S. Department of Justice has concluded on several occasions that the proposed plan of business of certain preferred provider organizations would not violate federal antitrust laws. Most recently, however, a preferred provider organization in Stanislaus County was found by the U. S. Department of Justice to be violating the federal antitrust laws based on anti-competitive price-fixing and restraint of trade agreements. While the California Attonery General has no opinion procedure similar to the U. S. Justice Department, we are aware of no reason why the state would take a position different from the

U. S. Department of Justice in this matter. In our view, therefore, the present antitrust laws provide an effective and efficient regulatory mechanism that should not be tampered with by the Legislature or the Administration. We also doubt that the antitrust laws have acted as a barrier to reducing health care costs through the use of preferred provider organizations. For example, the Sacramento Bee of September 26, 1984 (p. A-5) reported that Blue Cross of California had signed up over 10,000 doctors and 150 hospitals under its preferred provider organization, the "Prudent Buyer Plan." Blue Shield of California, under its "Blue Shield Preferred Plan" had contracted with 5 hospitals and over 1,500 physicians in Sacramento, alone. At the Assembly Judiciary Committee hearing on AB 707 last year, the California Medical Association reported that over 160 preferred provider organizations had been established since the enabling legislation was added to the Insurance Code in 1982. These facts do not indicate that a barrier exists to reducing health care costs through the use of preferred provider organizations.

20. The Department of Corporations does not believe that there is a problem with preferred provider organizations which would warrant additional legislation or regulation at this time. In fact, those preferred provider organizations which pose realistic risks to the consuming public are already subject to regulation. If the preferred provider arrangements are those of an admitted insurer or nonprofit hospital service plan, they are regulated by the Department of Insurance. If a preferred provider organization receives premiums or processes claims for an admitted insurer, it is subject to regulation by the Department of Insurance as an administrator. If a preferred provider organization is a health care service plan it is subject to regulation by the Deparment of Corporations. Whether problems requiring resolution by legislation of regulation will ever develop among those preferred provider organizations which are not now subject to regulation is unknown. Attempting to develop legislation or regulation to prevent or resolve unknown potential problems with preferred provider organizations would be inappropriate and ill-advised.

21. We are unaware of any serious problems which the public has experienced because health care service plans are licensed under the Knox-Keene Health Care Service Plan Act of 1975 by the Department of Corporations, and insurance companies, nonprofit hospital plans and others are subject to regulation of the Department of Insurance; nor are we aware of problems because health maintenance organizations are qualified by the federal government. As explained earlier, the Departments of Corporations and Insurance have procedures for dealing with those persons claiming exemption from licensure under either the Department of Corporations or Department of Insurance.

22. We are unaware of the bills to which you refer which mandate some health care services but exclude others. Generally, if the basis for the mandated health care services can be established, we will support the legislation. However, in many cases, special interest groups seek to require the provision of their services under mandated health care services without establishing the necessity for doing so or without allowing their specific health care services to be offered as an option.

23. The Department of Corporations does not maintain statistics based upon the immediate source of complaints received. Most consumer complaints are received directly from subscribers or enrollees, however. Some complaints are forwarded to us by solicitors or solicitor firms; others are forwarded by the Department of Insurance and certain federal agencies. It would take a considerable amount of staff time to reconstruct the exact number of complaints forwarded to us by the Department of Insurance during a statistically significant period. A rough estimate is approximately 10% of the complaints are forwarded by the Department of Insurance. Under the Knox-Keene Health Care Service Plan Act of 1975, the department reviews the adequacy of medical malpractice coverage because we feel it has a bearing on the financial viability of the health care service plan. Usually, a health care service plan carries its own medical malpractice insurance and/or is named as an insured under the health care provider's medical malpractice insurance policy. As you know, health care service plans contract with providers of health care in order to fulfill their obligations under a health care service plan contract. As discussed earlier, an informal procedure has already been established between the Departments of Corporations and Insurance. Complaints dealing with insurance companies and others regulated by the Department of Insurance are routinely forwarded to that department for handling. The informal procedure presently in effect is sufficient and we know of no reason to institute a formal, legislatively mandated procedure.

24. All complaints dealing with health care service, coverage, or plans are processed in the Health Care Service Plan Division by a person who directs the complaint, as necessary, to a health analyst (if a health care related complaint is made), to an attorney (if a complaint involves contractual, legal or regulatory interpretation), to an examiner (if the complaint involves the financial requirements or viability), or to the Department's Enforcement Division if disciplinary action appears appropriate or if an investigation is necessary to take administrative, civil or criminal action. The licensing and financial examination sections of the Health Care Service Plan Division are involved, as necessary, depending on the nature of the complaint.

25. The Commissioner and the Department of Corporations have jurisdiction over persons engaging in activities relating to health care service plans by virtue of the definitions contained in the Knox-Keene Health Care Service Plan Act of 1975. To the extent that persons calling themselves "administrators", "medical care foundation", "preferred provider organizations", or "exclusive provider organizations" meet the definition of "health care service plan" and are not excluded from jurisdiction under Health and Safety Code Section 1343(d), then these persons are subject to the Knox-Keene Health Care Service Plan Act of 1975. The terms "solicitor" and "solicitor firms" are defined under the Knox-Keene Health Care Service Plan Act of 1975 and these persons are subject to regulation when engaging in activities under that law. With respect to the definitions found in the Knox-Keene Health Care Service Plan Act of 1975, see Health and Safety Code Sections 1343(f), (l), (m), and (n).

26. We believe this question is directed primarily to the Department of Insurance. To the extent that this question deals with the disclosure requirements imposed by Health and Safety Code Section 1346.5, we have attached a copy of Commissioner's Release 14-H.

27. We believe that it is realistically impossible for a preferred provider organization subject to regulation of the Insurance Code to also be subject to regulation under the Knox-Keene Health Care Service Plan Act of 1975 as a solicitor or solicitor firm. As set forth previously, we have issued Commissioner's Release 14-H and two interpretive opinions under the Knox-Keene Health Care Service Plan Act of 1975 (OP 4730H and OP 4664H), both of which are attached to this letter.

28. We have no statistics showing the growth rate with respect to these businesses. It is our understanding, however, that preferred provider organizations do not have an "unfunded risk" since many appear to be agents for health care providers and perform administrative functions. It is also our understanding that provider contracts are on a fee-for-service basis, but at a reduced fee-for-service rate. The Department of Corporations and the Department of Insurance continue to exchange information regarding preferred provider organizations informally, primarily through supervising investigators. We see no need to require statutorily mandated formal arrangements for the exchange of information.

29. At present, regulation of various types of health care businesses proceeds along functional lines. The present statutory and regulatory schemes have proved sufficient to regulate and encourage health care in California and, without a clear showing of necessity, we do not believe a change is necessary. As to the

indemnity element in some health care service plans, we believe Health and Safety Code Section 1377 provides protection to health care consumers.

30. The administration of the Knox-Keene Health Care Service Plan Act of 1975 by the Department of Corporations has been effective and provides protection to the public through licensure and regulation of health care service plan business and health care activities.

Very truly yours,

Franklin Tom

FRANKLIN TOM
Commissioner

February 19, 1985

OBTAINING A LICENSE UNDER

THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT

I. PURPOSE OF THE KNOX-KEENE ACT

A. JURISDICTIONAL PURPOSE

The Knox-Keene Act (Health and Safety Code Section 1340, et seq.) is intended to regulate health care services plans, defined in Section 1345(f) of the Act to include:

> ". . . any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees."

B. REGULATORY PURPOSES

The regulatory purposes of the Knox-Keene Act include both consumer protection and plan promotion. They are set forth in Section 1342(a) through (g) of the Knox-Keene Act, as follows:

(a) Assuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(b) Assuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace.

(c) Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(d) Helping to assure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Assuring the financial stability thereof by means of proper regulatory procedures.

(g) Assuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

The Department construes the requirements and prohibitions contained in the Act and the regulations, which are found in Subchapter 5.5 of Chapter 3 of Title 10 of the California Administrative Code (beginning at Rule 1300.40), in a manner consistent with the above legislative purposes and with due regard for the business needs of applicants and licensees as well as for the legitimate expectations of subscribers and enrollees.

II. PROCEDURES FOR OBTAINING A LICENSE UNDER THE KNOX-KEENE ACT

A. Initially, an applicant should determine its market and develop its plan of business, with due consideration to the Knox-Keene Act and rule requirements and established means of achieving compliance.

B. An applicant should arrange for a prefiling conference to occur approximately six to 12 weeks prior to its projected filing date.

C. An applicant should file three complete, legible copies of an internally consistent application containing all the information necessary to demonstrate compliance with the provisions of the Knox-Keene Act and regulations, together with the appropriate filing fee. Three complete copies are necessary to facilitate processing.

D. An applicant should respond rapidly and completely to the Department's comment letters, in each case providing in signed amendments the precise additional information requested in a manner demonstrating compliance. Three complete, legible copies of all amendments prior to licensure are necessary to facilitate processing.

E. The timing of licensure under the Knox-Keene Act is largely within the control of the applicant. Under perfect circumstances a license could be issued to an applicant presenting an initial application demonstrating compliance with all the provisions of the Knox-Keene Act and regulations within two months from the date of application. Normally, however, an administratively and financially competent applicant which has submitted a quality, reasonably complete application may expect to be licensed within six months of the date of application if no new, complex approaches to compliance are presented, if the applicant can rapidly provide quality amendments to provide necessary additional information or to cure deficiencies, and if entrance into the market within this time frame is important to its plan of business. A substantially incomplete or "problem" application may require considerably more than six months to process, may be declared abandoned for lack of pursuit, or may be denied for failure to demonstrate compliance with the Knox-Keene Act and rules.

F. A license can be issued under Section 1353 of the Knox-Keene Act only when an applicant has satisfied the provisions of the Act and regulations and the Department concludes that a disciplinary action pursuant to Section 1386 would not be warranted against the applicant.

III. DEMONSTRATING COMPLIANCE WITH THE PROVISIONS OF THE KNOX-KEENE ACT AND REGULATIONS

The items set forth below indicate key elements which applicants typically find necessary to include in applications or prelicensure amendments to demonstrate compliance with the provisions of the Knox-Keene Act and regulations. However, this discussion does not purport to be mandatory or exhaustive.

A. ORGANIZATION AND ADMINISTRATION

SUMMARY STATEMENT

The plan shall have the organizational and administrative capacity to provide or arrange for the provision of the basic health care services, and shall ensure that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management.

SUGGESTIONS

1. Incorporation and Governing Documents. Normally, a separate corporation limited to the health care service plan business is desirable. Whether or not separately incorporated, an applicant should submit articles of incorporation and bylaws which delineate the internal affairs of the applicant.

2. Organizational Chart. An applicant should provide an organizational chart showing the lines of responsibility and authority in the administration of its plan throughout its total management structure, including key positions and departments of the applicant (and of any affiliate and/or health care provider involved in plan management or any administrative services provider).

3. Explanation of Organization. The organizational chart should be accompanied by a narrative explanation, including, for example, the responsibility and authority of each entity, board, committee, and position.

4. Contracts. Contracts for administrative or management services or consulting should be provided together with a description of the applicant's arrangements to monitor the performance of these contracts and to protect the plan, its enrollees, and providers in case of a failure of performance or contract termination.

5. Medical Decision Making. An applicant should describe how it will provide for separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management.

6. Other. In addition to disclosing its affiliate structure, an applicant should disclose its principals and creditors, and its financial transactions involving affiliates, principals, or creditors.

B. HEALTH CARE DELIVERY SYSTEM

SUMMARY STATEMENT

The health care delivery system shall make available the health care services required under the Act on a basis affording accessibility and continuity, and providing quality of care review within its service area.

SUGGESTIONS

1. Basic Health Care Services. Full-service plans must provide all of the basic health care services, defined in Section 1345(b) to include:

   (1) Physician services, including consultation and referral.

   (2) Hospital inpatient services and ambulatory care services.

   (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

   (4) Home health services.

   (5) Preventive health services.

   (6) Emergency health care services, including ambulance services and out-of-area coverage. (See Rule 1300.67.)

2. Accessibility. All enrollees should have a residence or workplace within 30 minutes or 30 miles of contracting or plan-operated primary care providers according all enrollees a ratio of at least one FTE primary care provider per each 2,000 enrollees, and to a contracting or plan-operated hospital. However, patterns of usage in a particular community (including, for example a particular age group) may require greater geographical accessibility or, in a medically underserved rural area, lesser accessibility. Plans providing services to Medicare enrollees may need to consider factors such as the availability of public transportation, for example. Reasonable accessibility to tertiary care, as well as to necessary ancillary services, should be provided.

3. Hospital Admitting Privileges. Each contracting or plan-employed primary care physician and specialist should have admitting staff privileges at at least one contracting or plan-operated hospital providing a full range of health care services.

4. Description of Service Area. An applicant should describe its service area in terms of geographical areas (political subdivision boundaries and natural boundaries) and should indicate the zip codes within the service area.

5. Map of Service Area. The description should be accompanied by a map clearly indicating the boundaries of the service area, ordinary geographic detail (such as highways and major streets), and the location of contracting or plan-operated hospitals, major (or "aggregated") primary care providers and specialists, and, to the extent feasible, ancillary providers.

6. Arrangements with Health Care Providers. An applicant should demonstrate that it has adequate arrangements with health care providers. For full service plans, this requires sufficient contracting or plan-owned primary care physicians and specialists, hospitals, and providers of ancillary services to provide the six basic health care services (Sections 1345(b) and 1367(i), and Rule 1300.67) to its subscribers and enrollees.

7. Provider/Enrollee Ratios. Calculation of provider/enrollee ratios should be provided.

8. Accessibility Monitoring. An applicant's monitoring program for accessibility should be provided.

9. Referrals. A description of applicant's system of making and documenting referrals to physicians and other health professionals should be provided.

10. Quality of Care Review. An applicant's system for the review of the quality of health care to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization, and the cost of services should be documented.

11. Contracts with Providers. Contracts with providers must be submitted, except that only a specimen of each type of standard form contract need be filed along with any variations to be used in the terms and provisions.

    Amounts of payments to providers should be deleted from these contracts, and, instead, submitted separately, together with the provider's signature on the execution page, as confidential information but clearly identified to the full text of the contracts. Executed provider contracts are essential; although they need not necessarily be submitted initially, delays in submission are among the factors which may prevent licensure by an applicant's projected start-up date.

    It is helpful if an applicant provides a tabular-form schedule indicating the pertinent statutory and regulatory provisions and the section, paragraph, or page number of the complying provision in each type of provider contract. Among the provisions which should be included in provider contracts are provisions (a) prohibiting a provider from billing for or collecting from subscribers or enrollees moneys owed but not paid by the plan, (b)

requiring record-keeping required under the Act, (b) requiring cooperation with an applicant's quality of care review system and the Department of Corporations' medical surveys, and (c) obligating the provider to perform any other obligations intended to be imposed by the plan, such as participation in prior authorization, utilization review, and quality of care activities.

C. FINANCIAL SOUNDNESS

SUMMARY STATEMENT

The plan shall have a fiscally sound operation and adequate provision against the risk of insolvency, and shall provide periodic financial reports.

1. Enrollment Projections. Monthly enrollment projections for group contracts and individual contracts, if any, should be provided to cover the period beginning with the commencement of operations as a licensed plan until the projected break-even point (or one year, whichever is longer). Quarterly enrollment projections for group contracts and individual contracts, if any, should be provided for an additional period of one year after the projected break-even point. (Medi-Cal, Medicare, and Medicare supplement coverages should normally be treated as individual contracts, and each should be labeled as such.)

2. Substantiation and Letters. Enrollment projections should be substantiated by a descrpition of the facts and assumption used, and documentation should include reliable market surveys and letters of interest or intent from each identified group on letterhead of the group and signed by its representative.

3. Prepaid or Periodic Charges. Prepaid or periodic charges should be fixed for individual and group contracts, and the method used to determine these charges should be discussed. The facts and assumptions upon which the charges are based and the documentation substantiating the validity of the facts and assumptions should be provided. The prepaid or periodic charges should be disclosed for each group contract and each individual contract.

4. Collection of Prepaid Charges. An applicant should describe how it will collect prepaid and periodic charges and copayments from its subscribers and enrollees. If prepaid or periodic charges will be paid by subscribers to any entity other than the plan, the entity and the measures used to safeguard and account for such funds should be disclosed.

5. Current Financial Viability. Current financial viability should be established by providing the most recent audited financial statements of applicant, accompanied by an opinion of an independent certified public accountant or independent public accountant, together with all footnotes. If the audited financial

statements are for a period ended more than 60 days before the date of filing an application, financial statements as of a date not later than 60 days prior to filing should be submitted; these more recent financial statements need not be audited so long as they are prepared in accordance with generally accepted accounting principles.

6. Current Tangible Net Equity. Current tangible net equity should be calculated in accordance with Rule 1300.76 based on the most recent balance sheet submitted.

7. Projected Financial Viability Prior to Start-Up. An applicant may demonstrate projected financial viability prior to start-up by providing projected financial statements of the applicant reflecting actual and projected changes which have occurred or expected to occur after the date of its most recent financial statements and prior to the date projected for the commencement of plan operations. Projected financial statements should be prepared in accordance with generally accepted accounting principles and on a basis consistent with the submitted financial statements. Included should be a projected balance sheet as of the projected start-up date, a projected statement of income and expenses for the period ending with the start-up date, and a calculation of the applicant's projected tangible net equity as of its projected start-up date and in accordance with its projected balance sheet.

8. Projected Financial Viability During and After Initial Period of Operations. Projected financial statements as of the close of each month during an applicant's initial period of operations (through the break-even point or one year, whichever is longer) and as of the close of each quarter for the following year should be prepared on a basis consistent with the projected financial statements submitted for the period prior to start-up. These should include a projected balance sheet as of the close of each month (during "initial period") or quarter, (during the "following year"), projected statement of income and expense for each such month or quarter, projected cash-flow statement for each such month or quarter, a calculation of an applicant's tangible net equity as of each such month or quarter, and a calculation of applicant's administrative costs pursuant to Rule 1300.78 for each such month or quarter.

9. Feasibility Studies/Actuarial Reports. The assumptions and conclusions upon which an applicant's projections are based should be substantiated by the complete results of feasibility studies obtained by an applicant as normally required by conventional lending institutions, including at least legal, marketing/enrollment, providers, and financial. An actuarial report should also be provided. It should include for enrollees covered by community rated contracts, and for each experience rated contract: utilization rates for each medical expense item reflected in its projected income statements, the cost per utilization unit for

each medical expense item (including methodology and source of data for cost computations), the per member per month cost for each medical expense item, the methodology and source of data used to estimate copayments, coordination of benefits, and reinsurance recoveries including expression on a per member per month basis, and inflation estimates used in the projections and the source used to establish such estimates.

10. Community Rating vs. Experience Rating. A summary schedule should be provided to reflect the breakdown of the total revenue and expense included in the projected income statements by community rated contracts and experience rated contracts, or, if inapplicable, explain.

11. Delivery--Payment Time Lag. An applicant should also indicate the assumptions made to determine the time lag between the delivery of covered health care services and applicant's payment for those services, and all other assumptions made in preparing the projected cash flow statements for its initial operating period.

12. Tangible Net Equity Prior to Break-Even Point. An applicant should describe in detail any measures taken or proposed to be taken to maintain compliance with the tangible net equity requirement of Rule 1300.76 and the financial viability requirement of Rule 1300.76.1 in view of losses and expenditures prior to reaching a break-even point in its operations. Included should be a schedule setting forth the amounts of any additional needed funding and the dates when such amounts will be infused into the applicant. If these arrangements involve arrangements for additional capital, to subordinate or postpone the payment of accounts, notes or other obligations of the plan or other agreements, an applicant should provide a copy of these agreements (or cite to them, if otherwise submitted) and should identify their applicable provisions and the parties thereto and their relationship to the plan and its affiliates. If any funding is to be obtained from an entity other than a national bank or a bank incorporated under the laws of the State of California, a copy of such entity's most recent annual audited and quarterly unaudited financial statements should be provided.

13. Reimbursements. An applicant should provide monthly projections until the break-even point or one year, whichever is later, and quarterly projections for the next year of each of the three types of reimbursement payments (to noncontracting providers, to enrollees for services provided by noncontracting providers, and to contracting providers), and should set forth the ratios indicated in Section 1377. An applicant should also describe and substantiate the facts and assumptions upon which the projections are based, and, if any of the ratios exceeds 10 percent, indicate how the applicant will comply with the pertinent provisions of Section 1377 and related rules.

14. Administrative Costs. If an applicant's administrative costs (Rule 1300.78) as projected for its initial period of operation exceed 25 percent of the prepaid or periodic charges, it should provide a calculation of the percentage of administrative costs to such charges and explain the necessity for the projected level of administrative costs and indicate how it will reduce costs to not more than 15 percent of such charges within five years after licensure.

15. Provision for Extraordinary Losses. Legible copies of actual or specimen copies of policies of insurance (with any riders or endorsements) showing all of the terms and conditions should be submitted for the following: to respond to claims for damages arising out of furnishing health care services (malpractice insurance), to respond to tort claims (other than malpractice), and to protect against losses of facilities due to fire or other causes. Evidence of fidelity bond coverage pursuant to Rule 1300.76.3 should also be submitted.

16. Fiscal Arrangements. To demonstrate maintenance of financial viability, an applicant should describe its arrangements to comply with Section 1375.1(b) and Rule 1300.75.1(a)(2), and, if insurance is involved in these arrangements, furnish a specimen policy, name of the insurer, and the premium cost. If an applicant intends to capitate any provider, it should indicate the percentage of contracting providers to be capitated and should provide information regarding capitation payments to providers (the method used to determine and adjust the capitation rates, and substantiation or justification of adequacy). To demonstrate adequate provision for the risk of insolvency, an applicant should indicate how it will provide, in the event of insolvency, for the continuation of benefits to enrollees for the duration of the period for which payment has been made, the continuation of benefits until discharge for enrollees confined as in-patients on the date of insolvency, and payments to noncontracting providers for services rendered.

17. Provider Claims. A description of an applicant's system for processing claims from contracting providers and noncontracting providers for payment, and from subscribers and enrollees for reimbursement, should be provided. (See Rule 1300.77.4.)

18. Other Business. If an applicant is or will engage in any business other than as a health care service plan, it should describe such other business, its relation to its business as a plan, and the anticipated financial risks and liabilities of such other business, and should explain if its financial statements and projections do not include such other business.

D. SUBSCRIBER CONTRACTS, DISCLOSURES, AND RELATIONS

SUMMARY STATEMENT

The plan may market or issue only those plan contracts which include the provisions required under the Act and regulations and are "fair, reasonable, and consistent with the purposes of the Act", shall fully and fairly disclose to prospective and actual subscribers and enrollees the benefits and other terms of the plan contract, and shall maintain required internal procedures to consider and resolve enrollee grievances, and shall provide for enrollee participation in the public policy of the plan.

SUGGESTIONS

1. Plan Contracts. An applicant should submit copies of the health care service plan contracts it will issue, including standard form contracts and any variations in their provisions. An applicant should also identify the particular provisions of these contracts which comply with the provisions of the Act and rules, or which vary therefrom. Any proposed variances should be explained and justified. (Requests for variances from rules will be considered if requested and well justified.) Group contracts and individual contracts should be submitted separately, as should be a tabular-form schedule indicating the pertinent statutory and regulatory provisions and the complying provisions of the contract(s). (Some statutory requirements expressly apply only to group contracts.) A troublesome area for many applicants is the proper statement of benefits, any copayments, deductibles, limitations, or exclusions which may apply, and requirements relating to prior authorization or referral to specialists.

2. Disclosure Forms. An applicant should submit a copy of each disclosure form which it proposes to use, and identify by name and exhibit number the contract(s) with which the disclosure form will be used. Any potential difficulties in understanding any disclosure form(s) in relation to the related contract, and the means of avoiding these difficulties, should be discussed. An applicant should also provide a tabular-form schedule indicating the pertinent statutory and regulatory provisions and the section, paragraph, or page number of the complying provision in the disclosure form(s). Many applications experience difficulty achieving full and fair disclosure of benefits, any copayments, deductibles, limitations, or exclusions which apply, any requirements relating to prior authorization or referral to specialists, and the location of principal facilities and their hours of operation. This information should also be disclosed in the evidence of coverage (see Item 3, below) or in any combined evidence of coverage and disclosure form (see Item 4, below).

3. Evidence of Coverage. An applicant should provide a copy of each evidence of coverage which it proposes to use. Each evidence of coverage should relate to one form of plan contract, to which it should be identified by name and exhibit number; however, an evidence of coverage for alternative plans may be allowed if it clearly identifies the alternatives and their effect and if the alternative contracts are clearly identified by name and

exhibit number. An applicant should also provide a tabular-form schedule indicating the pertinent statutory and regulatory provisions and the section, paragraph, or page number of the complying provision in the evidence(s) of coverage. The evidence of coverage must be consistent with the plan contract as to benefits and any copayments, deductibles, limitations, and exclusions, and other terms and provisions.

4. Combined Evidence of Coverage and Disclosure Forms. An applicant may combine the evidence of coverage and disclosure form into one document if it complies with the requirements set forth in Rule 1300.63.2. An applicant should submit any combined evidence of coverage and disclosure forms which it proposes to use. Each combined document should relate to one form of plan contract, to which it should be identified by name and exhibit number; however, a combined document offering alternative plans or options may be allowed if it clearly identifies the alternatives and their effect and if the alternative contracts are clearly identified by name and exhibit number. An applicant should also provide a tabular-form schedule indicating the pertinent statutory and regulatory provisions and the section, paragraph, or page number of the complying provision in the combined evidence of coverage and disclosure form.

Enrollee/Subscriber Grievance Procedures. An applicant should provide a copy of its written grievance procedures, adopted or to be adopted to comply with the provisions of Section 1368 and Rules 1300.68, 1300.85, 1300.85.1, a copy of its complaint forms, and an explanation of how its grievance procedures will be made available to subscribers and enrollees. If the written grievance procedures do not identify the key personnel of applicant and provider organizations that will be responsible for carrying out the grievance procedures and the review of the results, each person should be identified by name, title, and description of his or her responsibility for carrying out the grievance procedures.

6. Public Policy Participation. If an applicant is in compliance with the requirements of the federal Health Maintenance Organization Act of 1973, and intends to rely on such compliance to satisfy the provisions of Section 1369 of the Act, it should so indicate and provide necessary documentation. Otherwise, an applicant should describe in detail how it intends to comply with the provisions of Section 1369 and Rule 1300.69. For example, it may require that one-third of its governing board be subscribers or enrollees, or it may establish a standing committee which reports to the applicant's governing board and meets certain other requirements.

E. MARKETING PLAN CONTRACTS

SUMMARY STATEMENT

The plan may market its group and individual contracts only in an orderly manner which affords full and fair disclosure to prospective subscribers and enrollees.

SUGGESTIONS

1. Marketing Group Contracts. An applicant should describe the methods by which it proposes to market group contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation, and how an applicant will secure compliance with rules governing marketing.

2. Marketing Individual Contracts. An applicant should describe its program for marketing individual contracts as indicated above.

3. Supervision of Marketing. An applicant should describe its internal arrangements to supervise the marketing of its plan contracts, including the name and title of each person with primary management responsibility for the employment and qualification of solicitors, advertising, and contracts with solicitors and solicitor firms, and for monitoring compliance with contractual and regulatory provisions.

4. Solicitation Contracts. Each contract or proposed contract between an applicant and any person (other than an employee whose only compensation is by salary) soliciting or agreeing to solicit the sale of plan contracts on behalf of an applicant. However if a standard form contract is used, it may be submitted along with an identification of the terms and provisions which may be varied and a copy of each variation. If these contracts do not show the rate of compensation to be paid, a list should be included to show the name of all such persons and the rate and form of compensation.

SUGGESTIONS

1. Marketing Group Contracts. An applicant should describe the methods by which it proposes to market group contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation, and how an applicant will secure compliance with rules governing marketing.

2. Marketing Individual Contracts. An applicant should describe its program for marketing individual contracts as indicated above.

3. Supervision of Marketing. An applicant should describe its internal arrangements to supervise the marketing of its plan contracts, including the name and title of each person with primary management responsibility for the employment and qualification of solicitors, advertising, and contracts with solicitors and solicitor firms, and for monitoring compliance with contractual and regulatory provisions.

4. Solicitation Contracts. Each contract or proposed contract between an applicant and any person (other than an employee whose only compensation is by salary) soliciting or agreeing to solicit the sale of plan contracts on behalf of an applicant. However if a standard form contract is used, it may be submitted along with an identification of the terms and provisions which may be varied and a copy of each variation. If these contracts do not show the rate of compensation to be paid, a list should be included to show the name of all such persons and the rate and form of compensation.

* * *

Written inquiries may be directed to:

Department of Corporations
Health Care Service Plan Division
1107 9th Street, 8th Floor
Sacramento, California 95814

Telephone inquiries may be directed to:

(916) 324-9015 (Sacramento), (213) 736-3132 (Los Angeles)

February 21, 1985

THE TEN MOST COMMON OMISSIONS

IN APPLICATIONS FOR KNOX-KEENE LICENSURE

The following items are the ten most frequent omissions found in applications for licensure under the Knox-Keene Act. Avoiding these omissions, although they reference only a very few of the requirements for licensure, will improve the quality of your application. Before submitting your application, double check it to be sure that it is internally consistent, includes the following information, and clearly demonstrates compliance with all of the provisions of the Act (Section 1340, et seq., Health and Safety Code) and the Rules (Title 10, Chapter 5, Subchapter 5.5, California Administrative Code).

1. Financial projections including complete explanations of the assumptions with respect to premium income and expenses that are realistic, given the competitive environment, and a complete explanation of how projected losses will be funded, consistent with net equity requirements.

2. Disclosure of all affiliates of the applicant, as well as the financial and other relationships between the parties.

3. All administrative contracts, including contracts with interested parties.

4. Provider contracts showing a complete health care delivery system.

5. The service area of the applicant explained in terms of the geographic area (political subdivision boundaries and natural boundaries) in which the applicant proposes to market and be responsible for availability and accessibility of care, indicating the zip codes included therein.

6. A quality assurance system that matches the particular structure and delivery system of the applicant.

7. A description of the role of the medical director or comparable person.

8. Subscriber contracts and disclosure documents prepared according to the requirements of the Act and Rules.

9. Specimen copies of all required insurance policies.

10. Individual information sheets for all required persons.

For further information contact:

Department of Corporations
Health Care Service Plan Division
1107 9th Street, 8th Floor
Sacramento, California 95814
(916) 324-9015 or (213) 736-3132

STATE OF CALIFORNIA

DEPARTMENT OF CORPORATIONS

Copies of Title 10 of the California Administrative Code may be obtained from:

Office of Procurement
Documents Section
P.O. Box 1015
North Highlands, CA 95660
(916) 924-4800

Available Publications:

CALIFORNIA ADMINISTRATIVE CODE, TITLE 10 INVESTMENT (complete) ....$ 40.00
Annual Amendment Service.. 140.00
containing Rules and Regulations of:

Ch. 1. Supt. of Banks.....
Ch. 2. Savings & Loan Com.....
Ch. 3. Corporations Com.....
Ch. 4. Districts Securities.....
Ch. 5. Insurance Com.....
Ch. 6. Real Estate Com.....
Ch. 7. Job Development
Corporation Law
Executive Board

If the Rules and Regulations of the Commissioner of Corporations ONLY is required, order Title 10 Chapter 3, - Corporations Commissioner ...$ 20.00
Annual Amendment Service.. 40.00

Community Land Chests
Investment Advisers
Corporate Securities Law of 1968
Franchise Investment Law
Credit Unions
Industrial Loans
Limited Dividend Housing Corporation
Personal Property Brokers
Commercial Finance Lenders
Security Holders Protective Committee
Escrow Agents
Check Sellers and Cashers
Health Care Service Plans
Consumer Finance Lenders

For the Corporations Code, the Financial Code and/or the Health and Safety Code (Knox-Keene Health Care Service Plan Act of 1975), please contact vendors listed below:

Bancroft-Whitney Publishing Co.
West Publishing Company
Parker & Sons, Inc. (Corporations Code only)
Matthew Bender

STATE OF CALIFORNIA

DEPARTMENT OF CORPORATIONS

CUSTOMER AUTHORIZATION OF DISCLOSURE OF FINANCIAL RECORDS

Pursuant to Health and Safety Code Section 1351.1 or 1352, and Government Code Sections 7470 and 7473, any financial institution, wherever situated, possessing financial records of

_____

Name of (check appropriate designation(s) below)

_____ Health Care Service Plan
_____ Specialized Health Care Service Plan
_____ Association, Partnership, or Corporation controlling, controlled by, or otherwise affiliated with a health care service plan or specialized health care service plan

is hereby authorized to disclose to the California Department of Corporations any financial records of the above-named licensee under the Knox-Keene Health Care Service Plan Act of 1975 or any financial records of the above-named entity controlling, controlled by, or otherwise affiliated with such licensee whether such records relate to accounts which have been closed, accounts which are currently maintained, or accounts which are hereafter established.

This authorization is effective as of the date of execution and shall remain effective until five years after the expiration or revocation of the above-named license as a health care service plan or specialized health care service plan, including renewals of such license, or five years after the cessation of control or affiliation with a health care service plan or specialized health care service plan.

This authorization may not be revoked.

The terms used in this authorization shall have the definitions contained in the California Right to Financial Privacy Act (Government Code Section 7460 et seq.) and the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code Section 1340 et seq.).

The above-named licensee or other designated entity has duly caused this authorization to be signed on its behalf by the undersigned, thereunto duly authorized.

Executed on _____, 19____, at _____

_____
Licensee's Department of Corporations File Number

_____
Name of licensee or entity

By _____

_____
(Title)

HP 500.263 (3/77)

TO THE COMMISSIONER OF CORPORATIONS OF
THE STATE OF CALIFORNIA

CONSENT TO SERVICE OF PROCESS

KNOW ALL MEN BY THESE PRESENTS:

That the undersigned, _____,
(a corporation organized under the laws of the State of _____)
(a partnership) (an individual) (other _____)
hereby irrevocably appoints the Commissioner of Corporations of the State of California, or his successor in office, to be his (its) attorney to receive service of any lawful process in any noncriminal suit, action or proceeding against him (it), or his (its) successor, executor, or administrator which arises under the Knox-Keene Health Care Service Plan Act of 1975 or any rule or order thereunder after this consent has been filed, with the same force and validity as if served personally on the undersigned.

For the purpose of compliance with the Corporations Code of the State of California, notice of the service and a copy of the process should be sent by registered or certified mail to the undersigned at the following address:

_____
Name

_____
Street Address

_____
City State Zip Code

Dated: _____, 19___.

_____

By _____

Title _____

CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 19__, before me, _____, the undersigned officer, personally appeared _____ known personally to me to be the _____ of the above-named corporation (partnership), and that he, as such officer (general partner), being authorized so to do, executed the foregoing instrument for the purposes therein set forth, by signing the name of the corporation (partnership) by him as such officer (partner).

IN WITNESS WHEREOF I have hereunto set my hand and official seal.

_____ _____
My Commission expires Notary Public

INDIVIDUAL ACKNOWLEDGEMENT

STATE OF _____
COUNTY OF _____

On this _____ day of _____, 19____, before me, _____, the undersigned officer, personally appeared _____ to me personally known and known to me to be the same person(s) whose name(s) is (are) signed to the foregoing instrument, and acknowledged the execution thereof for the purposes therein set forth.

IN WITNESS WHEREOF I have hereunto set my hand and official seal.

_____ _____
My Commission expires Notary Public

STATE OF CALIFORNIA
DEPARTMENT OF CORPORATIONS

APPLICATION FOR PLAN LICENSE

Instructions

GENERAL INSTRUCTIONS

1. The application must be typewritten in the English language, using black ribbon.

2. Each item of the form must be completed. If inapplicable, type "N/A" in the right-hand margin opposite such item.

3. Each exhibit shall be numbered by the item number (and letter, if applicable) under which it is furnished. If several exhibits are required under the same number-letter designation, they shall be given, in addition, a sequential number as indicated in the following example.

   Example: In responding to Item 15A calling for copies of the plan contracts used by the applicant, an applicant employing three different contracts would label them as exhibits as follows: Exhibit 15A-1, Exhibit 15A-2, Exhibit 15A-3.

4. Except when originals are required, mechanical reproductions may be submitted. Each portion of the application and exhibits must be clearly legible.

5. When the space provided in the application form for the answer of a question is insufficient, the information must be provided in the form of an exhibit to the application numbered as specified in paragraph 3 above, and arranged in the same manner as indicated in the form.

6. Any reference herein to a rule or regulation of the Commissioner is to the rules of the Commissioner of Corporations as set forth in Title 10, California Administrative Code.

AMENDMENTS TO APPLICATION

1. An amendment to application before the issuance of a license must comply with Rule 1300.52 (see instruction 2 below). Rules 1300.52.1 and 1300.52.2 are not applicable until after an applicant has been licensed.

2. All amendments to application, before or after licensing, must comply with the following:

   a. The amendment must be accompanied by a copy of the Execution Page of the application, and all portions of that page must be completed.

   b. There should be attached to the Execution Page only those pages of the application or those exhibits which are changed by the amendment.

   c. If a page of the application is amended, all items on that page must be completed and the changed item must be "red-lined" or otherwise clearly designated.

   d. If an exhibit, other than a list required by Items 13A, 13C or 25D is being amended, the applicant shall either:

      (1) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or

      (2) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. If this method of amendment is employed, the applicant shall refile the entire exhibit as amended whenever more than 10% of its pages have been amended or promptly upon the request of the Commissioner.

   e. A list furnished pursuant to Items 13A, 13C or 25D need be amended only when 10 percent or more of the names contained in the list, or in the list for a service area, have been changed. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added item "redlined" and the names of persons deleted from the list shown at the end under the heading "deletions".

Official Use Only
Fee paid $_____
Receipt No. _____

DEPARTMENT OF CORPORATIONS
File No. _____
(Insert file number of previous filings before the Department, if any.)

Date of Application:

_____

FILING FEE: _____
(To be completed by Applicant.) Not refundable except pursuant to Section 250.15, Title 10, California Administrative Code.

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

Note: Indicate type of filing by checking the appropriate box below:
[ ] ORIGINAL APPLICATION FOR PLAN LICENSE
[ ] AMENDMENT TO APPLICATION FOR PLAN LICENSE

1. Name of Applicant.

A. Legal name: _____

B. Fictitious names used, if any: _____
_____

2. Applicant's Principal Executive Office.

A. Street Address: _____
_____

B. Mailing Address: _____
_____

C. Telephone Number: ( ) _____

3. Person who is to receive communications regarding this application.

A. Name: _____

B. Title: _____

C. Address: _____

D. Telephone Number: ( ) _____

IMPORTANT NOTE: Applicant is required to file an amendment to this application (1) prior to a major modification of its plan or operations (Rule 1300.52.1) and (2) within 30 days after any change in the information contained in this application, other than financial information (Rule 1300.52).

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4. EXECUTION: The applicant has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

_____ By _____
(Applicant) Title: _____

I certify under penalty of perjury that I have read this application and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true.

Executed at _____ on _____ 19____

_____
Signature of Declarant

(If executed outside of California, attach a verification executed and sworn to before a notary public.)

5. Name and address of officer or partner of applicant who is to receive compliance and informational communications from the Department and who is responsible for disseminating the same within the applicant's organization:

A. Name: _____

B. Title: _____

C. Address: _____

D. Telephone Number: ( ) _____

6. Form of Organization: State applicant's form of organization ("Corporation," "partnership," "sole proprietorship" or other appropriate description.)

A. _____

B. Is applicant a public agency? ( )Yes ( )No

7. Information on Organization: (In responding to this item use the appropriate exhibit form provided as part of the application.)

A. If applicant is a corporation, attach Exhibit 7-A ( )

B. If applicant is a partnership, attach Exhibit 7-B ( )

C. If applicant is a sole proprietorship, attach Exhibit 7-C ( )

D. If applicant's form of organization is other than a corporation, partnership or sole proprietorship, attach Exhibit 7-D ( )

E. As to each natural person named in an exhibit pursuant to Item 7, attach an Individual Information Sheet (Form HP 1300.51.1). ( )

8. Principal Creditors.

List each creditor (1) who has loaned funds to the applicant for the operation of its business or (2) who holds, directly or indirectly, 20% or more of the obligations of the applicant. For the purposes of this item, a creditor is considered to have loaned funds to the applicant for the operation of its business if (1) the creditor has any control over the operations of the applicant, directly or indirectly, or (2) the obligation is not secured and is not by its terms payable within 12 months.

Name	Address	Amount	Terms	Relationship to Applicant

If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

9. Does any person not named in Items 7 or 8 (or any exhibit thereto) have any power, directly or indirectly, to control applicant?

( )Yes ( )No

If "yes" explain fully.

10. Has the applicant, its management company, or any other affiliate of the applicant, or any controlling person, officer, director, or other person occupying a principal management position in such applicant, management company or affiliate ever been convicted of a misdemeanor involving moral turpitude or of a felony? (A plea or verdict of guilty or a conviction following a plea of nolo contendere is a conviction for the purposes of this item.)

( )Yes ( )No

If "yes," identify such person and explain fully. Such explanation should be included in the personal information sheet for such person, if required by Item 11.

11. For each person named in Item 8 or 9, or in any exhibit thereunder, furnish an exhibit containing the following information:

A. Name

B. Business address

C. Nature of business

D. Type of organization (corporation, partnership, sole proprietorship, individual, etc.)

E. If other than an individual, the names of such person's officers, directors, general partners or persons occupying similar positions or performing similar functions.

F. If a corporation which has 300 or more shareholders, the name of each person holding of record 5% or more of such corporation's equity securities.

G. If other than a corporation which has 300 or more shareholders, an individual or a sole proprietorship, the name of each person owning, directly or indirectly, 5% or more of such person's equity securities.

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If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

12. Description of Plan

A. State the service areas to be served by the applicant:

B. Attach as Exhibit 12-B a description of applicant's plan of operation, its method of providing for health care services, its physical facilities and, if applicable, its health care delivery capabilities, and the arrangements and methods by which health care services will be provided. If the applicant serves more than one service area, cover each service area separately and, for each service area, state the following information:

( )

1. The number of hospital beds contracted for, their locations and types of licenses.

2. The number of full-time and the number of part-time primary care physicians (as defined in Rule 1300.45(j)).

3. The specialties of, and the number of full-time and the number of part-time, non-primary care physicians in each specialty.

4. The major facilities of the Plan and of providers for the rendition of health services, and the health services provided at each such facility. For the purposes of this item, a "major facility" is any facility which provides, within the service area, 10 percent or more of the Plan's health services.

5. The approximate maximum number of enrollees and subscribers which can be effectively served by applicant's facilities, and the approximate maximum number which applicant intends to enroll. State the assumptions upon which these estimates are based.

13. Contracts with Providers and Others.

Instructions: (1) There may be omitted from the information required pursuant to this item contracts which are not material.
(2) If standard form contracts are used, only a specimen of such contract should be filed, together with a schedule showing as to each person with whom such standard form contract is entered into, the date of such contract and any material terms which vary in such contract from the standard form.
(3) Contracts of employment should not be filed pursuant to this item.

A. Attach for each service area of the applicant, a list of all contracts currently in effect between applicant and providers of health care services. The list for each service area should be separately numbered, be in columnar form, and show the name and address of the provider, a succinct statement of the type of service provided (e.g., hospital, pharmacy, physician, gynecology), and the exhibit number of the provider's contract furnished pursuant to Item 13B.

B. Attach a copy of each contract currently in effect between applicant and a provider of health care services. If such contract shows the payment rendered or to be rendered a

provider of health care services, such minimum portion of the contract as is necessary to prevent disclosure of such payment shall be deleted or blanked out by suitable means in the copy furnished as an exhibit available for public inspection. An additional unmarked copy of each contract shall be furnished as a confidential exhibit to the applicant, designated with the same exhibit number and clearly marked "confidential."

( )

C. Attach for each service area of the applicant, a list of all contracts currently in effect between applicant and any person for the performance of administrative functions or services for applicant. The list for each service area should be separately numbered, be in columnar form, and show the name and address of such person, a succinct statement of the type of service provided, and the exhibit number of the contract furnished pursuant to Item 13D.

D. Attach a copy of each contract currently in effect between applicant and any person agreeing to perform an administrative function or service for the applicant.

( )

E. Does applicant have any contract or arrangement, written or oral, with any person named in Items 7, 8 or 9, or in any exhibit thereunder, or with a person controlling, controlled by or under common control with applicant?

( )Yes ( )No

If "yes," furnish a copy of each such contract (or a description of such contract, if an oral contract) and a list thereof setting forth the name of such person and the exhibit number of such contract. Any contract furnished pursuant to parts "A", "B", "C" or "D" of this item need not be furnished under this part but must be included in the list.

F. Does any person named pursuant to parts "A" or "C" of this item have a financial interest in, or other relationship to, applicant not disclosed pursuant to Items 7, 8 or 9 or any exhibit thereunder?

( )Yes ( )No

If "yes," attach an exhibit explaining fully such interest or relationship. For the purpose of this item, "interest or relationship" means any interest or relationship which may indicate an absence of arms-length bargaining on behalf of the applicant with respect to such contract or arrangement.

14. Individual and Group Plan Contracts.

A. Attach a copy of each plan contract (a contract sold to individuals) and each group plan contract which is to be issued by the applicant or which has been issued by the applicant and is currently in effect. If standard form contracts are used, only a specimen of each standard form contract need be submitted, accompanied by a schedule or explanation of the variations which were made, or may be made, in such contracts when issued.

B. Does any plan contract furnished pursuant to Item 14-A fail to provide all of the basic health care services included in Subdivision (b) of Section 1345 of the Act and as defined by Rule 1300.67?

( )Yes ( )No

If "yes," attach a complete explanation.

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If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

C. 1. If applicant is a health care service plan, furnish as an exhibit a detailed description of each health care service, other than basic health care services, furnished by the plan to subscribers and enrollees.

2. If applicant is a specialized health care service plan, furnish as an exhibit a detailed description of the health care service furnished by the plan.

15. Medi-Cal Participation.

A. Does the applicant have a contract with the California Department of Health under the provisions of the Waxman-Duffy Prepaid Health Plan Act?

( )Yes ( )No

B. If "yes," state the date of its current contract and the number of persons enrolled in the plan pursuant thereto:

Date of contract:_____No. of enrollees:_____

C. If "no" is applicant seeking, or does it intend to seek, such a contract?

( )Yes ( )No

16. Health Maintenance Organization Act of 1973.

A. If applicant is not currently qualified under such Act, has it applied for or does it intend to apply for such qualification?

( )Yes ( )No

B. Is the applicant a qualified organization under the provisions of such Act?

( )Yes ( )No

C. Has applicant received any grants, loans or loan guarantees under the provisions of the Act?

( )Yes ( )No

17. Internal Review of Quality of Care.

Attach as an exhibit a description of applicant's procedures and programs for internal review of the quality of health care pursuant to the requirements of the Act.

18. Method of Subscriber-Enrollee Participation in Plan Policy.

Attach as an exhibit a description of the mechanism by which enrollees and subscribers will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan, pursuant to Section 1369 of the Act.

19. Subscriber-Enrollee Grievance Procedure.

A. Attach as an exhibit a description of the enrollee-subscriber grievance procedure to be utilized as required by Section 1368 of the Act.

B. Attach as an exhibit a copy of the complaint form proposed to be used by the applicant pursuant to Section 1368(c) of the Act.

If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

20. Insurance Coverages.

The following should be attached as exhibits to the application.

A. Furnish evidence that applicant maintains adequate insurance or self-insurance to respond to claims against applicant for damages arising out of the furnishing of health care services.

B. Furnish evidence that applicant maintains adequate insurance, or self-insurance, to cover its liabilities for tort claims, other than with respect to claims for damages arising out of the furnishing of health care services.

C. Furnish evidence that applicant maintains adequate insurance coverage or self-insurance to protect against losses of facilities upon which it has the risk of loss due to fire or other causes. Indentify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.

D. Identify all facilities described in Item 12 upon which applicant has the risk of loss due to fire or other causes which are not covered by the information provided in response to "C" above and explain the failure to provide such insurance, including if pertinent a description of currently effective insurance maintained by others upon such facilities and whether such coverage is required pursuant to a contract with the applicant.

E. File a copy of the fidelity bond obtained by applicant pursuant to Rule 1300.76.3.

F. Furnish evidence of adequate workmen's compensation insurance coverage against claims which may arise against applicant.

21. Evidence of Coverage, Disclosure Materials.

A. Furnish a copy of each form of evidence of coverage which is currently used by applicant or which applicant proposes to use.

B. Furnish a copy of each disclosure form which is currently used by the applicant or which applicant proposes to use.

22. Financial Information.

A. Attach as an exhibit a copy of applicant's financial statements, consisting of at least a balance sheet and statement of income and expenses, prepared as of a date within 90 days of the filing of this application. This statement need not be certified, but if not certified, also attach as an exhibit its most recent certified financial statements of the applicant as of the close of its last fiscal year.

B. Attach as an exhibit a calculation of applicant's tangible net equity prepared in accordance with Rule 1300.76.

If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

C. Attach as an exhibit a schedule of the rates and charges adopted by the applicant.

D. Attach an exhibit fully describing the method used by the applicant to determine the rates and charges to individual and to group subscribers.

E. Does applicant:

1. Reimburse providers of health care services that do not contract in writing with the plan to provide health care services for a specified consideration?

( )Yes ( )No

2. Reimburse its subscriber-enrollees for expenditures incurred in having received health care services from providers that do not contract with applicant?

( )Yes ( )No

3. Reimburse providers of health care services on a fee-for-service basis?

( )Yes ( )No

If any of the above is answered "yes" state the percent which such reimbursements are of the applicant's total expenditures for health care services during each calendar quarter of the preceding two calendar years (or if applicant has not operated for two years or has not made such reimbursements for that period, for such lesser period).

F. If the amount of reimbursements reported pursuant to item E-1 and/or E-2 above exceeds 10 percent, answer the following questions.

1. Does applicant maintain cash or cash equivalents at least equal to the aggregate sum of the last four months of reimbursable payments which were made and accrued to such providers of service and its subscribers and enrollees?

( )Yes ( )No

2. Does applicant maintain adequate insurance to compensate for any loss resulting from the insolvency of the applicant?

( )Yes ( )No

If "yes" furnish a complete description of such insurance and evidence that such insurance is currently in effect.

G. Subsequent Provider Requirement.

1. Does applicant qualify for an exemption from the subsequent provider requirement pursuant to Subdivision (d) of Section 1375 of the Act?

( )Yes ( )No

If "yes" attach as an exhibit an application for such exemption setting forth the basis therefore, including a certified financial statement for the fiscal year preceding the fiscal year

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If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

covered by the certified statement filed pursuant to Item 23A.

2. If applicant does not apply for an exemption from the Subsequent Provider Requirement, furnish the following information:

   a. Name of subsequent provider:

   _____

   b. A copy of the subsequent provider agreement.

   c. A copy of the program for implementing the subsequent provider agreement, as required by Rule 1300.75.

   d. Does applicant, or any person named pursuant to Items 7, 8, 9 or 13, have any financial, business or personal relationship with the subsequent provider, its officers, directors, partners, shareholders or affiliates?

   ( )Yes ( )No

If "yes" explain fully.

3. Does applicant have an agreement to act as a subsequent provider?

   ( )Yes ( )No

If "yes" supply a copy of the agreement and a copy of the program for the implementation thereof.

4. Does applicant apply for an exemption from the subsequent provider requirement of Section 1375 of the Act pursuant to Section 1300.75.3, Title 10, Calif. Admin. Code? ( )Yes ( )No

If "yes" attach as an exhibit to the application a narrative statement describing the applicant's approach to fiscal soundness and the provisions made relative to its ability to meet its contractual obligations in respect to the risk of insolvency. The presentation should include the following:

   a. Projections on a quarterly basis for the ensuing year covering enrollments, the utilization of health services and expenditures therefore by major category, administrative expenses, debt servicing requirements, cash flow and sources of funds. Such projections should be accompanied by a written statement of the assumptions related thereto and the basis for assuming their validity.

   b. For Plans with less than five years operating experience or which contemplate a material expansion of operations, the complete results of feasibility studies, as normally required by conventional lending institutions, in each of these areas: legal, market/enrollment, providers and financial.

   c. Describe the approach and specific provisions made against the risk of insolvency including, but not limited to, any risk-taking or insurance arrangements with outside organizations. (See Subsections (b) and (c) of Section 1300.75.3.)

H. Is applicant engaged in any business other than the operation of the plan?

( )Yes ( )No

If "yes" attach an exhibit fully describing such other business.

23. Marketing of Plan Contracts.

A. Attach an exhibit describing the method(s) by which applicant proposes to market plan contracts, including the method of compensation to employees and outside solicitors for sales.

B. Attach as an exhibit, a copy of each form or agreement which will be shown to or completed by subscribers or enrollees (other than forms submitted pursuant to Item 22).

C. Attach as an exhibit a copy of each form of contract or proposed contract between applicant and any person agreeing to solicit on behalf of applicant and a list showing the name and address of each such contracting party.

D. Name and address of applicant's officer, management or supervisory employee who will supervise the solicitation of plan sales.

_____ _____

(Name) (Title)

_____

(Address)

24. Exhibits.

Attach the following exhibits to the application, numbering each exhibit by the item number of letter indicated below. If any exhibit is not applicable, so indicate by marking the appropriate box.

	Exhibits Not Applicable
A. A copy of each of the basic organizational documents of the applicant, such as the articles of incorporation, association or partnership, trust agreement, and all amendments thereto.	( )
B. A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.	( )
C. A Consent to Service of Process, if applicant is other than a California corporation (Form HP1351-J).	( )
D. A list setting forth the name, business address, and license number of each physician employed by or contracting with the applicant to provide medical services, to the extent that this does not duplicate information required by Item 14. Such list should be furnished by service area and the names listed alphabetically.	( )

If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

CALIFORNIA
DEPARTMENT OF CORPORATIONS

EXHIBIT 7-A to APPLICATION FOR HEALTH PLAN LICENSE

For Corporations.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A)

2. State of Incorporation. 3. Date of Incorporation.

4. Is applicant a nonprofit corporation?
( )Yes ( )No

5. Is applicant exempted from taxation as a nonprofit corporation?
( )Yes ( )No

6. Names of principal officers, directors and shareholders: List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially over 5% of the voting securities of applicant or over 5% of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk(**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Relationship			Class of Equity Security	Percent of Class
Last	First	Middle	Beginning Date		Title or Status		
			Mo.	Year			

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

CALIFORNIA
DEPARTMENT OF CORPORATIONS

EXHIBIT 7-B to APPLICATION FOR HEALTH PLAN LICENSE

For Partnerships.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A).

2. State of organization. 3. Date of organization.

4. Names of Partners and Principal Management: List all general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title, status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Beginning Date		Type of Partner	Capital Contribution (%)	Title or Duties
Last	First	Middle	Mo.	Year			

5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

CALIFORNIA
DEPARTMENT OF CORPORATIONS

EXHIBIT 7-C to APPLICATION FOR HEALTH PLAN LICENSE

For Sole Proprietorship.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A).

2. Residence Address.

3. Names of persons performing principal management functions: List each person who occupies a principal management position or who performs principal management functions for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title or duties is being reported and place a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

Full Name Last First Middle	Beginning date		Title and Duties
	Mo.	Year	

4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

CALIFORNIA
DEPARTMENT OF CORPORATIONS

EXHIBIT 7-D to APPLICATION FOR HEALTH PLAN LICENSE

For organizations other than corporations, partnerships and sole proprietorships.

To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A)

2. State of Organization 3. Date of Organization

4. Form of Organization (describe briefly)

5. Names of Principal Officers and Beneficial Owners: List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions, and (b) each person who owns of record or beneficially over 5% of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent previous filing.

Full Name			Beginning Date		Class of Equity Security	Percent of Class	Title and Duties
Last	First	Middle	Mo.	Year			

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

GEORGE DEUKMEJIAN, GOVERNOR, STATE OF CALIFORNIA
FRANKLIN TOM, COMMISSIONER OF CORPORATIONS

NOTICE OF PROPOSED CHANGES
IN THE REGULATIONS OF THE COMMISSIONER OF CORPORATIONS
UNDER THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

NOTICE IS HEREBY GIVEN that FRANKLIN TOM, Commissioner of Corporations of the State of California, pursuant to the authority vested by Section 1344 of the Health and Safety Code and to implement, interpret and make specific provisions of the Knox-Keene Health Care Service Plan Act, proposes to adopt, amend or repeal regulations in Subchapter 5.5, Chapter 3, Title 10, California Administrative Code.

INFORMATIVE DIGEST

1. Section 1300.45(c) now defines "affiliate" and provides that the definition does not apply to Sections 1351.1 or 1352 of the Knox-Keene Health Care Service Plan Act ("Act"), while no definition is currently provided of the term "affiliated person". The employment of these terms in the Act requires that they be defined. Accordingly, Subsection (c) of Section 1300.45 is proposed to be amended to delete the reference to Sections 1351.1 and 1352 and to include a definition of "affiliated person".

Authority Cited: Section 1344, Health and Safety Code.
Reference: Sections 1351 and 1352, Health and Safety Code.

2. Section 1300.51 sets forth the requirements of an application for health care service plan license as adopted in 1976. It does not reflect subsequent changes to the Act. The proposed changes in the rule reflect changes in the Act, such as the repeal of Section 1375 relating to "subsequent providers", reorganize the information required to eliminate duplication, provide for comprehensive instructions for presenting the health care delivery system, including plan administration, and facilitate a coordinated presentation of enrollment projections and financial viability information. Transition to the new application is provided for both pending applications and existing licensees. General instructions for preparation are transferred to a new section for clarity (see below).

Authority Cited: Section 1344, Health and Safety Code.
Reference: Sections 1351, 1351.1, 1352, 1359, 1363, 1367, 1367.2, 1367.3, 1367.5, 1367.6, 1367.7, 1367.8, 1367.9, 1367.15, 1368, 1369, 1370, 1370.1, 1373, 1373.1, 1373.2, 1373.4, 1373.5, 1373.6, 1373.7, 1373.8, 1374, 1374.7, 1374.10, 1374.11, 1374.12, 1375.1, 1376, 1377, 1378, 1399.62 and 1399.63, Health and Safety Code.

DOCUMENT OP 05/84-A

3. Section 1300.51.1 specifies the information which individuals are required to provide in connection with an employment or other affiliation with a health care service plan. The questions relating to employment and other business affiliations are being amended to make it clear that the information elicited includes employments and other business affiliations with health care service plans, and to cite the proposed definition of "affiliated person" in Section 1300.45(c)(2).

Authority Cited: Section 1344, Health and Safety Code.
Reference: Section 1351, Health and Safety Code.

4. The instructions for preparing and amending an application for health care service plan license are currently set forth in Section 1300.51. The substantial revision of that section necessitates a corresponding restatement and revision of the instructions. Section 1300.51.3 is proposed to be adopted setting forth the revised instructions.

Authority Cited: Section 1344, Health and Safety Code.
Reference: Section 1351, Health and Safety Code.

5. Section 1300.52 currently sets forth the instructions for an amendment to its application by an existing licensee. These instructions are based on the existing application form and do not reflect the revisions to that form referred to in item 1 above. Section 1300.52 is proposed to be amended to indicate portions of the new application which need not be amended by existing licensees and to provide added instructions when applicable portions of the application are amended:

Authority Cited: Section 1344, Health and Safety Code.
Reference: Sections 1351 and 1352, Health and Safety Code.

5. Section 1300.67.11 currently refers to item numbers in Section 1300.51 to identify the persons whose transactions evoke its provisions. Proposed changes to Rule 1300.51 will change the item numbers and Section 1300.67.11 is proposed to be changed to reflect that revision.

Authority Cited: Section 1344, Health and Safety Code.
Reference: Section 1351 and Subdivision (h) of Section 1367, Health and Safety Code.

The text of the proposed regulations may be obtained upon request from any office of the Department of Corporations. Request Document OP 05/84-B. A statement of reasons for the proposed action is also available. Request Document OP 05/84-C. The Office of Policy also maintains a rulemaking file containing all the information upon which the proposal is based. The rulemaking file may be inspected by the public at the Sacramento Office of the Department of Corporations. Comments or inquiries concerning these proposed regulation changes may be directed to Robert E. La Noue, Assistant Commissioner, (916) 322-3553.

Notice is also given that any interested person may present statements or arguments relevant to the proposed action by a written communication addressed to the Commissioner of Corporations at 1025 P Street, Room 205, Sacramento, California, 95814, on or before 5 p.m., May 29, 1985 . Any interested person or his or her duly authorized representative may request, in writing, a public hearing pursuant to Section 11346.8 of the Government Code received no later than 15 days prior to the close of the written comment period by the Office of Policy, Sacramento Office of the Department of Corporations at the above address. The text of any regulation as modified, unless the modification is only nonsubstantial or solely grammatical in nature, will be made available to the public at least 15 days prior to the date on which the Department of Corporations adopts the regulations. A request for a copy of any regulations as modified should be addressed to the agency official identified above. The Commissioner will accept written comments on the regulations as modified for 15 days after the date on which they are made available.

The Commissioner may thereafter adopt, amend or repeal the foregoing proposals substantially as set forth above without further notice.

The potential cost impact of the proposed action on private persons or businesses directly affected is expected to be insignificant. The Commissioner has determined that the proposed action will not have a significant adverse economic impact on small business within the meaning of Chapter 1083, Statutes 1982.

I hereby certify that these regulations do not impose a mandate on a local agency or school district or that there is no increased or new cost to local agencies or school districts pursuant to Section 2231 of the Revenue and Taxation Code that will result from the proposed adoption, amendment or repeal of regulations contained in this notice. This also certifies that there are no direct or indirect costs or savings to any state agency, no other nondiscretionary costs or savings imposed on local agencies, and no costs or savings in federal funding to the state which would result from the adoption of the proposed action.

Dated: February 28, 1985
Sacramento, California

FRANKLIN TOM
Commissioner of Corporations

ROBERT E. LA NOUE
Assistant Commissioner

DOC 550 2/85 by DOC LA 0131

STATE OF CALIFORNIA

DEPARTMENT OF CORPORATIONS

TEXT OF PROPOSED CHANGES UNDER THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975 PURSUANT TO NOTICE OF PROPOSED CHANGES

DATED: February 28, 1985

1. Amend Subdivision (c) of Section 1300.45 to read:

(c) ~~Except in connection with Sections 1351.1 and 1352 of the Act, "an~~

(1) An "affiliate" of a person is a person controlled by, under common control with, or controlling such person.

(2) A person's relationship with another person is that of an "affiliated person" if such person is, as to such other person, a director, trustee or a member of its executive committee or other governing board or committee, or that of an officer or general partner, or holds any other position involving responsibility and authority similar to that of a principal officer or general partner; or who is the holder of 5% or more of its outstanding equity securities; or who has any such relationship with an affiliate of such person. An affiliate is also an affiliated person.

NOTE: Authority Cited: Sections 1344 and 1352, Health and Safety Code.

Reference: Section 1351, 1351.1 and 1352, Health and Safety Code.

2. Amend Section 1300.51 to read:

1300.51. Application for License as a Health Care Service Plan or Specialized Health Care Service Plan.

(a) An application for license as a health care service plan or specialized health care service plan shall be filed ~~on~~ in the ~~following~~ form, specified in subsection (c) and contain the

information specified in this section and prepared as required by Rule 1300.51.3.

(b) Applications filed prior to the effective date of Subsection (c) (revised plan application form) and which remain pending on that date will be processed; however, amendments to such applications filed prior to licensure shall be filed upon the form specified in Subsection (c) in accordance with the instructions specified in Rule 1300.51.3, and in accordance with the correlation table for the old and new applications provided in Form HCSP _____. Such amendments will be required only to update the information contained in the application and to remedy deficiencies in the information provided therein.

(c) Revised Health Care Service Plan Application Form.

~~GENERAL INSTRUCTIONS~~

~~1. The application must be typewritten in the English language, using black ribbon.~~

~~2. Each item of the form must be completed. If inapplicable type "N/A" in the right-hand margin opposite such item.~~

~~3. Each exhibit shall be numbered by the item number (and letter, if applicable) under which it is furnished. If several exhibits are required under the same number-letter designation, they shall be given, in addition, a sequential number as indicated in the following example.~~

~~Example: In responding to Item 15A calling for copies of the plan contracts used by the applicant, an applicant employing three different contracts would label them as exhibits as follows: Exhibit 15A-1, Exhibit 15A-2, Exhibit 15A-3.~~

~~4. Except when originals are required, mechanical reproductions may be submitted. Each portion of the application and exhibits must be clearly legible.~~

~~5. When the space provided in the application form for the answer of a question is insufficient, the information must be provided in the form of an exhibit to the application numbered as specified in paragraph 3 above, and arranged in the same manner as indicated in the form.~~

~~6. Any reference herein to a rule or regulation of the Commissioner is to the rules of the Commissioner of Corporations as set forth in Title 10, California Administrative Code.~~

~~AMENDMENTS TO APPLICATION~~

~~1. An amendment to application before the issuance of a license must comply with Rule 1300.52 (see instruction 8 below). Rules 1300.50.1 and 1300.50.2 are not applicable until after an applicant has been licensed.~~

~~2. All amendments to application, before or after licensing, must comply with the following:~~

~~a. The amendment must be accompanied by a copy of the Execution Page of the application, and all portions of that page must be completed.~~

~~b. There should be attached to the Execution Page only those pages of the application or those exhibits which are changed by the amendment.~~

~~c. If a page of the application is amended, all items on that page must be completed and the changed item must be "redlined" or otherwise clearly designated.~~

~~d. If an exhibit, other than a list required by Items 12A, 12C or 24D is being amended, the applicant shall either:~~

~~(1) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or~~

~~(2) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. If this method of amendment is employed, the applicant shall refile the entire exhibit as amended whenever more than 10% of its pages have been amended or promptly upon the request of the Commissioner.~~

~~e. A list furnished pursuant to Items 10A, 10C or 24D need be amended only when 10 percent or more of the names contained in the list, or in the list for a service area, have been changed. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added item "redlined" and the names of persons deleted from the list shown at the end under the heading "deletions".~~

6. Amend Section 1300.67.11 to read:

1300.67.11. Disclosure of Conflicts of Interest.

(a) A plan shall not enter into any transaction with a person currently named in Item F of its application under Section 1300.51 (or currently named pursuant to Items 7, 8 or 9 of that application as in effect prior to the effective date of Section 1300.51.3) unless, prior

thereto, each of the following conditions is met:

(1) The material facts concerning the transaction and the person's interest therein are disclosed to the governing body of the plan.

(2) The transaction is approved by a disinterested majority of the governing body.

(3) Such facts and such approval are made a part of the minutes of such governing body or, if no minutes are required of such governing body, otherwise retained as a record of the plan.

(b) A plan shall promptly give written notice to the Commissioner if a transaction is entered into otherwise than in conformity with the terms of this section.

(c) For the purposes of this section, "governing body" means the board of directors, all general partners, the sole proprietor, the board of trustees, and any other persons occupying a similar position or performing similar functions.

NOTE: Authority Cited: Section 1344, Health and Safety Code. Reference: Section 1351 and Subdivision (h) of Section 1367, Health and Safety Code.

(e) If an exhibit, other than a list required by Item 13A, 13C or 24D of the old application form or Item I-1, I-2 or I-3 of the new application is being amended:

(i) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or

(ii) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. If this method of amendment is employed, the applicant shall refile the entire exhibit as amended whenever more than 10% of its pages have been amended or promptly upon the request of the Commissioner.

(f) A list furnished pursuant to Items 13A, 13C or 24D of the old application or Item I-1, I-2 or I-3 of the new application need be amended only when 10 percent or more of the names contained in the list for a service area have been changed. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added item "redlined" and the names of persons deleted from the list shown at the end under the heading "deletions".

OFFICIAL USE ONLY
FEE PAID $_____
RECEIPT NO. _____

Date of Application:

DEPARTMENT OF CORPORATIONS
FILE NO. _____
(Insert file number of previous filings before the Department, if any.)
FILING FEE: _____
(To be completed by Applicant.) Not refundable except pursuant to Section 250.15, Title 10, California Administrative Code

~~DEPARTMENT OF CORPORATIONS~~
~~STATE OF CALIFORNIA~~

~~*Note: Indicate type of filing by checking the appropriate box below.~~
~~☐ ORIGINAL APPLICATION FOR PLAN LICENSE~~
~~☐ AMENDMENT TO APPLICATION FOR PLAN LICENSE~~

~~1. Name of Applicant~~
~~A. Legal name~~
~~B. Fictitious names used, if any:~~

~~2. Applicant's Principal Executive Office~~
~~A. Street Address~~
~~B. Mailing Address~~
~~C. Telephone Number ( )~~

~~3. Person who is to receive communications regarding this application~~
~~A. Name~~
~~B. Title~~
~~C. Address~~
~~D. Telephone Number ( )~~

~~IMPORTANT NOTE: Applicant is required to file an amendment to this application (1) prior to a major modification of its plan of operations (Rule 1300.88.1) and (2) within 30 days after any change in the information contained in this application, other than financial information (Rule 1300.88).~~

~~4. EXECUTION. The applicant has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.~~

~~(Applicant)~~ ~~By~~
~~Title~~

~~I certify, under penalty of perjury, that I have read this application and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true.~~

~~Executed at _____ on _____, 19__~~

~~Signature of Declarant~~

~~If executed outside California, attach a verification sworn to before a notary public.~~

~~5. Name and address of officer or partner of applicant who is to receive compliance and informational communications from the Department and who is responsible for disseminating like copies within the applicant's organization.~~
~~A. Name~~
~~B. Title~~
~~C. Address~~
~~D. Telephone Number ( )~~

~~6. Form of Organization. State applicant's form of organization ("corporation," "partnership," "sole proprietorship" or other appropriate description.)~~
~~A~~
~~B. Is applicant a public agency?~~ ~~( ) Yes~~ ~~( ) No~~

~~7. Information on Organization. (In responding to this item use the appropriate exhibit form provided as part of the application.)~~
~~A. If applicant is a corporation, attach Exhibit 7-A~~ ~~( )~~
~~B. If applicant is a partnership, attach Exhibit 7-B~~ ~~( )~~
~~C. If applicant is a sole proprietorship, attach Exhibit 7-C~~ ~~( )~~
~~D. If applicant's form of organization is other than a corporation, partnership or sole proprietorship, attach Exhibit 7-D~~ ~~( )~~
~~E. As to each natural person named in an exhibit pursuant to Item 7, attach an Individual Information Sheet (Form HP 1300.81.1).~~ ~~( )~~

~~8. Principal Creditors.~~
~~List each creditor (1) who has loaned funds to the applicant for the operation of its business or (2) who holds, directly or indirectly, 20% or more of the obligations of the applicant. For the purposes of this item, a creditor is considered to have loaned funds to the applicant for the operation of its business if (1) the creditor has any control over the operations of the applicant, directly or indirectly, or (2) the obligation is not secured and is not by its terms payable within 12 months.~~

~~Name Address Amount Terms Relationship to Applicant~~

~~If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.~~

~~9. Does any person not named in Items 7 or 8 (or any exhibit thereto) have any power, directly or indirectly, to control applicant? ( ) Yes ( ) No~~
~~If "yes" explain fully.~~

~~10. Has the applicant, its management company, or any other affiliate of the applicant, or any controlling person, officer, director, or other person occupying a principal management position in such applicant, management company or affiliate ever been convicted of a misdemeanor involving moral turpitude or of a felony? (A plea of guilty or a conviction following a plea of *nolo contendere* is a conviction for the purposes of this item.) ( ) Yes ( ) No~~
~~If "yes," identify such person and explain fully. Such explanation should be included in the personal information sheet for such person, if required by Item 11.~~

~~11. For each person named in Item 8 or 9, or in any exhibit thereunder, furnish an exhibit containing the following information:~~
~~A. Name.~~
~~B. Business address.~~
~~C. Nature of business.~~
~~D. Type of organization (corporation, partnership, sole proprietorship, individual, etc.).~~
~~E. If other than an individual, the names of such person's officers, directors, general partners or persons occupying similar positions or performing similar functions.~~
~~F. If a corporation which has 300 or more shareholders, the name of each person holding of record 5% or more of such corporation's equity securities.~~
~~G. If other than a corporation which has 300 or more shareholders, an individual or a sole proprietorship, the name of each person owning, directly or indirectly, 5% or more of such person's equity securities.~~

~~If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.~~

~~18. Description of Plan.~~
~~A. State the service areas to be served by the applicant.~~

~~B. Attach as Exhibit 18-B a description of applicant's plan of operation, its method of providing for health care services, its physical facilities and, if applicable, its health care delivery capabilities, and the arrangements and methods by which health care services will be provided. If the applicant serves more than one service area, cover each service area separately and, for each service area, state the following information:~~

~~(→)~~

~~1. The number of hospital beds contracted for, their locations and types of licenses.~~
~~2. The number of full time and the number of part time primary care physicians (as defined in Rule 1300.45(m)).~~
~~3. The specialties of, and the number of full time and the number of part time, non-primary care physicians in each specialty.~~
~~4. The major facilities of the Plan and of providers for the rendition of health services, and the health services provided at each such facility. For the purposes of this item, a "major facility" is any facility which provides, within the service area, 10 percent or more of the Plan's health services.~~
~~5. The approximate maximum number of enrollees and subscribers which can be effectively served by applicant's facilities, and the approximate maximum number which applicant intends to enroll. State the assumptions upon which these estimates are based.~~

~~19. Contracts with Providers and Others.~~
~~Instructions: (1) There may be omitted from the information required pursuant to this item contracts which are not material.~~
~~(2) If standard form contracts are used, only a specimen of such contract should be filed, together with a schedule showing as to each person with whom such standard form contract is entered into, the date of such contract and any material terms which vary in such contract from the standard form.~~
~~(3) Contracts of employment should not be filed pursuant to this item.~~
~~A. Attach for each service area of the applicant, a list of all contracts currently in effect between applicant and providers of health care services. The list for each service area should be separately numbered, be in columnar form, and show the name and address of the provider, a succinct statement of the type of service provided (e.g. hospital, pharmacy, physician, gynecology), and the exhibit number of the provider's contract furnished pursuant to Item 19B.~~
~~B. Attach a copy of each contract currently in effect between applicant and a provider of health care services. If such contract shows the payment rendered or to be rendered a provider of health care services, such minimum portion of the contract as is necessary to prevent disclosure of such payment shall be deleted or blanked out by suitable means in the copy furnished as an exhibit available for public inspection. An additional unmarked copy of each contract shall be furnished as a confidential exhibit to the applicant, designated with the same exhibit number, and clearly marked "confidential."~~

~~(←)~~

~~of the application, and each page of or exhibit submitted in support~~ of an amendment shall be completed as to all items required to be stated therein, including information which is not changed by the amendment. The changed portions of each application page and exhibit shall be indicated in the manner specified in the instructions to the application form, and shall comply with the following:

(a) The following portions of the application specified in Rule 1300.51 need not be amended after the issuance of a license:

Item E Summary of Information in Application

Item H-2 Map of Service Area.

Item H-3 Index to Map.

Item V Advertising.

Item CC Group Contract Enrollment Projections.

Item DD Individual Contract Enrollment Projections.

Item EE Summary of Enrollment Projections

Item GG Current Financial Viability including Tangible Net Equity.

Item HH Projected Financial Viability.

(b) The amendment must be accompanied by a copy of the Execution Page of the application, and all portions of those pages must be completed.

(c) Attach to the Execution Page only those pages of the application and/or those exhibits which are changed by the amendment.

(d) If a page of the application is amended, complete all items on that page and "redline" or otherwise clearly designate the changed item.

(c) Updating Application Prior to Licensure. In addition to complying with Rule 1300.52, an amendment to a pending application shall comply with the following:

(1) Material changes (see Rule 1300.45(1)) to information previously submitted in connection with an application (as amended to date) shall be submitted as an amendment to the license application immediately, except as provided in Subsection (f) of Rule 1300.52.

(2) Nonmaterial changes to the information previously submitted in connection with an application (as amended to date) may be accumulated and shall be submitted as a amendment to the license application monthly or within 30 days (or other period requested by the Commissioner) of each such change.

(3) Financial statements and calculations of tangible net equity previously submitted in connection with an application (as amended to date) shall be updated by an amendment to the license application which shall consist of quarterly financial statements (see Rule 1300.84.2a(1), (2), and (3)) and a calculation of applicant's tangible net equity as of the closing date of such quarter, and shall be filed within 30 days after the close of each quarter of applicant's fiscal year.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1351 and 1352, Health and Safety Code.

5. Amend Section 1300.52 to read:

Section 1300.52. Amendments to Plan Application

An amendment to a plan application pursuant to subdivision (a) of Section 1352 or by an applicant prior to licensing shall be filed upon the form contained in Section 1300.51 ~~and shall consist of (1) a completed Execution Page and/or each exhibit to the application which is amended. The Execution Page, each page~~

~~G. Attach for each service area of the applicant, a list of all contracts currently in effect between applicant and any person to the or from any administrative function or services for applicant. The list for each service area, as at the same term, and show the name and address of each person, a succinct statement of the type of service provided, and the exhibit number of the contract furnished pursuant to Item 13D.~~

~~D. Attach a copy of each contract currently in effect between applicant and any person agreeing to perform an administrative function or service for the applicant.~~

~~( ) ( )~~

~~E. Does applicant have any contract or arrangement, written or oral, with any person named in Items 7, 8 or 9, or in any exhibit thereunder, or with a person controlling, controlled by or under common control with applicant?~~

~~( ) Yes ( ) No~~

~~If "yes," furnish a copy of each such contract (or a description of such contract, if an oral contract) and a list thereof setting forth the name of each person and the exhibit number of such contract. Any contract furnished pursuant to parts "A", "B", "C" or "D" of this item need not be furnished under this part but must be included in the list.~~

~~F. Does any person named pursuant to parts "A" or "C" of this item have a financial interest in, or other relationship to, applicant not disclosed pursuant to Items 7, 8 or 9 or any exhibit thereunder?~~

~~( ) Yes ( ) No~~

~~If "yes," attach an exhibit explaining fully such interest or relationship. For the purpose of this item, "interest or relationship" means any interest or relationship which may indicate an absence of arms-length bargaining on behalf of the applicant with respect to such contract or arrangement.~~

~~14. Individual and Group Plan Contracts.~~

~~A. Attach a copy of each plan contract (a contract sold to individuals) and each group plan contract which is to be issued by the applicant or which has been issued by the applicant and is currently in effect. If standard form contracts are used, only a specimen of each standard form contract need be submitted, accompanied by a schedule or explanation of the variations which were made, or may be made, in such contracts when issued.~~

~~B. Does any plan contract furnished pursuant to Item 14 A fail to provide all of the basic health care services included in Subdivision (b) of Section 1345 of the Act and as defined by Rule 1300.67?~~

~~( ) Yes ( ) No~~

~~If "yes," submit a complete explanation.~~

~~C. 1. If applicant is a health care service plan, furnish as an exhibit a detailed description of each health care service, other than basic health care services, furnished by the plan to subscribers and enrollees.~~

~~2. If applicant is a specialized health care service plan, furnish as an exhibit a detailed description of the health care service furnished by the plan.~~

~~15. Medi-Cal Participation.~~

~~A. Does the applicant have a contract with the California Department of Health under the provisions of the Waxman-Duffy Prepaid Health Plan Act?~~

~~( ) Yes ( ) No~~

~~B. If "yes," state the date of its current contract and the number of persons enrolled in the plan pursuant thereto.~~

~~Date of contract _____ No. of enrollees _____~~

~~C. If "no" is applicant seeking, or does it intend to seek, such a contract?~~

~~( ) Yes ( ) No~~

~~16. Health Maintenance Organization Act of 1973.~~

~~A. If applicant is not currently qualified under such Act, has it applied for or does it intend to apply for such qualification? ( ) Yes ( ) No~~

~~B. Is the applicant a qualified organization under the provisions of such Act?~~

~~( ) Yes ( ) No~~

~~C. Has applicant received any grants, loans or loan guarantees under the provisions of the Act? ( ) Yes ( ) No~~

~~17. Internal Review of Quality of Care.~~

~~Attach as an exhibit a description of applicant's procedures and programs for internal review of the quality of health care pursuant to the requirements of the Act.~~

~~18. Method of Subscriber-Enrollee Participation in Plan Policy.~~

~~Attach as an exhibit a description of the mechanism by which enrollees and subscribers will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan, pursuant to Section 1369 of the Act.~~

~~19. Subscriber-Enrollee Grievance Procedure.~~

~~A. Attach as an exhibit a description of the enrollee-subscriber grievance procedure to be utilized as required by Section 1368 of the Act.~~

~~B. Attach as an exhibit a copy of the complaint form proposed to be used by the applicant pursuant to Section 1368(c) of the Act.~~

~~90. Insurance Coverage.~~

~~The following are the minimum standards for insurance coverage:~~

~~A. Furnish evidence that applicant maintains adequate insurance or self-insurance to respond to claims against applicant for damages arising out of the furnishing of health care services.~~

~~B. Furnish evidence that applicant maintains adequate insurance, or self-insurance, to cover its liabilities for tort claims, other than with respect to claims for damages arising out of the furnishing of health care services.~~

~~C. Furnish evidence that applicant maintains adequate insurance coverage or self-insurance to protect against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.~~

~~D. Identify all facilities described in Item 18 upon which applicant has the risk of loss due to fire or other causes which are not covered by the information provided in response to "C" above and explain the failure to provide such insurance, including if pertinent a description of currently effective insurance maintained by others upon such facilities and whether such coverage is required pursuant to a contract with the applicant.~~

~~E. File a copy of the fidelity bond obtained by applicant pursuant to Rule 1300.76.3.~~

~~F. Furnish evidence of adequate workmen's compensation insurance coverage against claims which may arise against applicant.~~

~~91. Evidence of Coverage, Disclosure Materials.~~

~~A. Furnish a copy of each form of evidence of coverage which is currently used by applicant or which applicant proposes to use.~~

~~B. Furnish a copy of each disclosure form which is currently used by the applicant or which applicant proposes to use.~~

~~92. Financial Information.~~

~~A. Attach as an exhibit a copy of applicant's financial statements, consisting of at least a balance sheet and statement of income and expenses, prepared as of a date within 90 days of the filing of this application. This statement need not be certified, but if not certified, also attach as an exhibit its most recent certified financial statements of the applicant as of the close of its last fiscal year.~~

~~B. Attach as an exhibit a calculation of applicant's tangible net equity prepared in accordance with Rule 1300.76.~~

~~C. Attach as an exhibit a schedule of the rates and charges adopted by the applicant.~~

~~D. Attach an exhibit fully describing the method used by the applicant to determine the rates and charges to individual and to group subscribers.~~

~~E. Does applicant:~~

~~1. Reimburse providers of health care services that do not contract in writing with the plan to provide health care services for a specified consideration?~~

~~( ) Yes ( ) No~~

~~2. Reimburse its subscriber enrollees for expenditures incurred in having received health care services from providers that do not contract with applicant?~~

~~( ) Yes ( ) No~~

~~3. Reimburse providers of health care services on a fee-for-service basis?~~

~~( ) Yes ( ) No~~

~~If any of the above is answered "yes" state the percent which such reimbursements are of the applicant's total expenditures for health care services during each calendar quarter of the preceding two calendar years (or if applicant has not operated for two years or has not made such reimbursements for that period, for such lesser period).~~

~~F. If the amount of reimbursements reported pursuant to item E-1 and/or E-2 above exceeds 10 percent, answer the following questions.~~

~~1. Does applicant maintain cash or cash equivalents at least equal to the aggregate sum of the last four months of reimbursable payments which were made and accrued to such providers of service and its subscribers and enrollees?~~

~~( ) Yes ( ) No~~

~~2. Does applicant maintain adequate insurance to compensate for any loss resulting from the insolvency of the applicant?~~ ~~( ) Yes ( ) No~~

~~If "yes" furnish a complete description of such insurance and evidence that such insurance is currently in effect.~~

~~G. Attach a narrative statement describing the applicant's approach to fiscal soundness and the provisions made relative to its ability to meet its contractual obligations in respect to the risk of insolvency. The presentation should include the following:~~

~~a. Projections on a quarterly basis for the ensuing year covering enrollments, the utilization of health services and expenditures therefore by major category, administrative expenses, debt servicing requirements, cash flow and sources of funds. Such projections should be accompanied by a written statement of the assumptions related thereto and the basis for assessing their validity.~~

~~b. The complete results of feasibility studies, as normally required by conventional lending institutions, in each of these areas: legal, market/enrollment, providers and financial.~~

~~c. Describe the approach and specific provisions made against the risk of insolvency including, but not limited to, any risk taking or insurance arrangements with outside organizations. (See Subsections (b) and (c) of Section 1300.76.3.)~~

~~H. Is applicant engaged in any business other than the operation of the plan?~~

~~( ) Yes ( ) No~~

~~If "yes" attach an exhibit fully describing such other business.~~

4. Adopt Section 1300.51.3 to read:

1300.51.3 Preparation and Amendment of Application for License as a Health Care Service Plan under Section 1300.51.

(a) General Instructions.

(1) Type the information requested in the English language using black ribbon.

(2) Complete each item on the application, and type "N/A" in the right hand margin for those items which are not applicable

(3) Number each exhibit as specified in the item to which the exhibit responds. If several exhibits are required under the same letter/number designation, add a sequential letter or roman numeral as indicated in the following example. Example: If Item Q-1 calls for copies of the specified documents, an applicant employing three different documents would label them as follows: Exhibit Q-1-a; Exhibit Q-1-b; Exhibit Q-1-c.

(4) Arrange all exhibits in sequential order. Attach a "tab" to the right margin of the first page of each major exhibit or series of exhibits to facilitate ready reference.

(5) Submit originals only when requested. Otherwise, submit clearly legible mechanical reproductions.

(6) Submit requested information as an exhibit if the space provided in the application form itself is insufficient. Use the procedure detailed in Item (3), above, to indicate the exhibit number.

(7) Submit three complete copies of the original license application and each amendment submitted prior to licensure.

(b) Amendment of an Application.

(1) An amendement to application either before or after issuance of a license must comply with Rule 1300.52. However, Rules 1300.52.1 and 1300.52.2 apply only after an applicant has been licensed.

For the purpose of compliance with the Corporations Code of the State of California, notice of the service and a copy of the process should be sent by registered or certified mail to the undersigned at the following address:

Name

Street Address

City State Zip Code

Dated: _____, 19____.

By _____

Title _____

CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 19____, before me, _____, the undersigned officer, personally appeared _____ known personally to me to be the _____ of the above-named corporation (partnership), and that he, as such officer (general partner), being authorized so to do, executed the foregoing instrument for the purposes therein set forth, by signing the name of the corporation (partnership) by him as such officer (partner).

IN WITNESS WHEREOF I have hereunto set my hand and official seal.

My Commission expires _____ Notary Public

INDIVIDUAL ACKNOWLEDGMENT

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 19____, before me, _____, the undersigned officer, personally appeared _____ to me personally known and known to me to be the same person(s) whose name(s) is (are) signed to the foregoing instrument, and acknowledged the execution thereof for the purposes therein set forth.

IN WITNESS WHEREOF I have hereunto set my hand and official seal.

My Commission expires _____ Notary Public

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code.

~~A. Attach an exhibit describing the method(s) by which applicant proposes to market plan contracts, including the method of compensation to employees and outside solicitors for sales.~~

~~B. Attach an exhibit demonstrating the plan's compliance and provisions for ongoing compliance with Section 1300.50.~~

~~C. Attach as an exhibit, a copy of each form or agreement which will be shown to or completed by subscribers or enrollees (other than forms submitted pursuant to Item 22).~~

~~D. 1. Attach as an exhibit a copy of each form of contract or proposed contract, including employment contract, between applicant and any person agreeing to solicit on behalf of applicant.~~

~~2. Attach a list showing the name and address of each person who contracts to engage in solicitation on behalf of the applicant, identifying each as a solicitor or a solicitor firm, as defined in Section 1345(*l*) and (m) of the Act. Persons licensed by the California Insurance Commissioner must be so identified.~~

~~E. Name and address of applicant's officer, manager or supervisory employee who will supervise the solicitation of plan sales.~~

~~(Name) (Title)~~

~~(Address)~~

~~24. Exhibits.~~

~~Attach the following exhibits to the application, numbering each exhibit by the item number of letter indicated below. If any exhibit is not applicable, so indicate by marking the appropriate box.~~

	~~Exhibits Not Applicable~~
~~A. A copy of each of the basic organizational documents of the applicant, such as the articles of incorporation, association or partnership, trust agreement, and all amendments thereto.~~	~~( )~~
~~B. A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.~~	~~( )~~
~~C. A Consent to Service of Process, if applicant is other than a California corporation (Form HP1251.1).~~	~~( )~~
~~D. A list setting forth the name, business address, and license number of each physician employed by or contracting with the applicant to provide medical services, to the extent that this does not duplicate information required by Item 13A. Such list should be furnished by service area and the names listed alphabetically.~~	~~( )~~

PLAN LICENSE APPLICATION
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT
(EXECUTION PAGE)

Identification of Plan.

1. Name of Applicant.

a. Legal name: _____

b. Please list all fictitious names you intend to use

_____

2. Applicant's Principal Executive Office.

a. Street Address: _____

b. Mailing Address: _____

c. Telephone Number: ( ) _____

3. Person who is to receive communications regarding this filing. (Note: Prior to licensure, the Department will correspond only with this person.)

a. Name: _____

b. Title: _____

c. Address: _____

d. Telephone Number: ( ) _____

4. EXECUTION: The applicant has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

By: _____
Signature of individual signing on behalf of Applicant

_____
(Applicant)

Name: _____
(Typed or printed)

Title: _____

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this application and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true and correct.

Executed at _____ (Place) on _____ (Date) 19 _____

Signature _____

10. Business ~~contacts and dealings (other than employment indicated in item 9)~~ contacts, dealings and affiliations (see Section 1300.45(c)(2)) with health care service plans during the last 5 years (other than employment indicated in item 9 but ~~include~~ including, for example, such roles as ~~officer,~~ director, stockholder, consultant, manager, provider and supplier, and such dealings as sales, leasing, and any contractural relationships) (list most recent business contracts and dealings first):

From	To	Plan Name and Address	Relationship and Duties

NOTE: Attach separate schedule if space is not adequate

11. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code or Health and Safety Code denied, revoked or suspended or been otherwise subject to disciplinary action, while you were in the employ of the applicant or while you had a contract with the applicant as a provider or otherwise? ☐ Yes ☐ No
If "yes" state the date of the action and the administrative body taking such action.

_____

12. Have you ever been convicted or pled *nolo contendere* to a misdemeanor involving moral turpitude or any felony, other than traffic violations? ☐ Yes ☐ No

If the answer is "yes" give details

_____

13. Have you ever changed your name or ever been known by any name other than that herein listed? (Including a married person's prior surname, if any.) ☐ Yes ☐ No

If so, explain. Change in name through marriage or court order should also be listed. EXACT DATE OF EACH NAME CHANGE MUST BE LISTED.

_____

14. Have you ever engaged in business under a fictitious firm name either as an individual or in the partnership or corporate form? ☐ Yes ☐ No

If the answer is "yes" set forth particulars

_____

3. Adopt Section 1300.51.5 to read:

1300.51.1. Individual Information Sheet.
An individual information sheet required pursuant to these rules shall be in the following form:

CONFIDENTIAL
See Note to Item 5

DEPARTMENT OF CORPORATIONS
State of California

INDIVIDUAL INFORMATION SHEET
under the
Knox Keene Health Care Service Plan Act of 1975
(California Health & Safety Code Sec. 1340 et seq.)

1. Name of Applicant _____ File No _____

2. Exact full name of person completing this statement: _____
First Middle Last

3. Physical Description:
Sex ____ Hair _____ Eyes _____ Height _____ Weight _____

4. Birthdate _____ Birthplace: _____

5. Social Security No. or
Taxpayer Ident. No. _____

NOTE: The inclusion of your social security number is not required but is voluntary. It is solicited pursuant to Sections 1344 and 1351 of the Health and Safety Code. It may be used to conduct a background investigation by the Department, the California Department of Justice Information Branch, or by other federal, state or local law enforcement agencies. This form, including the social security number, will be held confidential, but is a public record and available to the public pursuant to the Public Records Act (Gov. Code Section 6250), at the discretion of the Commissioner.

6. Residence Telephone 7. Business Telephone _____

8. Current Residence Address _____
Number and Street City State Zip

9. Employment for the last 5 years (list most recent first and include any employment with a plan or any person or entity which is or was affiliated with a plan (Section 1300.45(c)):

From	To	Employer Name and Address	Occupation and Duties
	Present		

NOTE: Attach separate schedule if space is not adequate

A. Type of Filing:

Indicate the type of filing by checking and completing the appropriate items:

1. ( ) Original application for a plan license.
2. ( ) Amendment # ___ to a pending application dated _____ for plan license. (Complete Item A-5 below.)
3. ( ) Notice of a proposed material modification in the form required by Rule 1300.52.1. (Complete Item A-5 below.)
4. ( ) Amendment filed by a licensee pursuant to Section 1352(a) because of a change in the information contained in the original application. (See Rule 1300.52 and complete Item A-5 below.)
5. Item numbers being amended _____
Exhibit numbers being amended _____

B. Type of Plan Contract(s): Indicate the type of a plan contract(s) by checking and completing the statements which most nearly describe the plan:

1. ( ) Full Service Health Plan Contracts which provide as benefits at least the six basic health care services listed in Section 1345(b) of the Act. (Check types below as appropriate.)
( ) Commercial
( ) Waxman-Duffy prepaid health plan contract
( ) Other Medi-Cal (Explain) _____
( ) MediCare Supplement
( ) Other (Explain) _____
2. ( ) Specialized Health Plan Contract(s)
( ) Dental ( ) Vision ( ) Mental Health ( ) Other _____

3. ( ) Contracts with subscribers and enrollees which are not limited to a single specialized area of health care but do not provide as benefits at least the six basic health care services listed in Section 1345(b) of the Act.

C. Name and address of officer or partner of applicant who is to receive compliance and informational communications from the Department and is responsible for disseminating the same within applicant's organization. (Note: After licensure, and except with respect to amendments and material modifications, the Department will correspond only with this person, unless the Department and applicant agree to other arrangements).

a. Name: _____

b. Title: _____

c. Address: _____

d. Telephone Number: ( ) _____

D. Other Agencies.

1. If applicant is seeking or intends to seek federal qualification under the Federal Health Maintenance Organization Act of 1973, check here _____.

2. If applicant has made or intends to make any filing relating to its plan to any other state or federal agency, check here _____, and attach Exhibit D-2 identifying each such agency, and the nature, purpose and (projected) date of each such filing.

Additional Exhibits: An original application for health care service plan license must include the completed form specified in this subsection and the exhibits required by Subsection (d).

(d) Exhibits to Plan Application.

E. Summary of Information in Application.

1. Summary Description of Plan Organization and Operation.

Provide as Exhibit E-1 a summary description of the organization and operation of applicant's business as a health care service plan, covering the highlights and essential features of the information provided in response to the other portions of this application which is essential or desirable to an effective overview of the applicant health care service plan business.

(4) Information form for Miscellaneous Types of Entities.

CALIFORNIA
DEPARTMENT OF CORPORATIONS

~~EXHIBIT-7-D-to-APPLICATION-FOR-HEALTH-PLAN-LICENSE For-organizations-other-than-corporations,-partnerships-and sole-proprietorships. To-be-used-in-response-to-Item-7-of-Form-HP-1300.51.~~

EXHIBIT F-1-d INFORMATION FORM FOR MISCELLANEOUS TYPES OF ENTITIES.

To be used in response to Item F-1-d of Form HP 1300.51.4

1. Name of Applicant (as in Item ~~1-A~~ D-1)

2. State of Organization 3. Date of Organization

4. Form of Organization (describe briefly)

5. Names of Principal Officers and Beneficial Owners. List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions, and (b) each person who owns of record or beneficially over 5% of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent previous filing.

Full Name			Beginning Date	Class of Equity	Percent of	Title and
Last	First	Middle	Mo. Year	Security	Class	Duties

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code.

2. State of organization 3. Date of organization.

4. Names of Partners and Principal Management: List all general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title, status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Beginning Date	Type of Partner	Capital Contribution (%)	Title or Duties
Last	First	Middle	Mo Year			

5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(3) Sole Proprietor Information Form.

CALIFORNIA
DEPARTMENT OF CORPORATIONS

~~EXHIBIT-7-C-to-APPLICATION-FOR-HEALTH-PLAN-LICENSE,~~
~~For-Sole-Proprietership,~~
~~To-be-used-in-response-to-Item-7-of-Form-1300.51.~~

1. Name of Applicant (as in Item 1-A D-1)

2. Residence Address

3. Names of persons performing principal management functions. List each person who occupies a principal management position or who performs principal management functions for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title or duties is being reported and place a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

Full Name			Beginning date	Title and Duties
Last	First	Middle	Mo. Year	

4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

2. Summary Description of Start-up. Provide as Exhibit E-2 a concise description of applicant's start-up program and its assumptions. Indicate applicant's projected date for the beginning of plan operations, and discuss the factors which require such date.

F. Organization and Affiliated Persons.

1. Type of Organization.

a. Corporation. If applicant is a corporation, and attach as Exhibits F-1-a-i, F-1-a-ii and F-1-a-iii, respectively, the Articles of Incorporation, Bylaws, and the Corporation Information Form. (Form HP 1500.4-A)

b. Partnership. If applicant is a partnership, and attach as Exhibits F-1-b-i, and F-1-b-ii, respectively, the Partnership Agreement, and the Partnership Information Form. (Form HP 1500.4-B)

c. Sole Proprietor. If applicant is a sole proprietorship, and attach as Exhibit F-1-c the Sole Proprietorship Information Form. (Form HP 1500.4-C)

d. Other Organization. If applicant is any other type of organization, and attach as Exhibit F-1-d, Articles of Association, trust agreement, or any other applicable documents, and any other organizational documents relating to the conduct of the internal affairs of the applicant, and attach as Exhibit F-1-d-ii the Information Form for other than Corporations, Partnerships, and Sole Proprietorships. (Form HP 1500.4-D)

e. Public Agency. If applicant is a public agency, and attach as Exhibit F-1-e-i a description of the public agency, its legal authority, organization, decision making body. Also attach as Exhibit F-1-e-ii a description of the division or unit of the public agency which is to be responsible for operating the plan, its legal authority, organization, and decision making role. Also attach as Exhibit F-1-e-iii the name and address of the local public agency which is the plan.

f. Individual Information Sheet. Attach as Exhibit F-1-f, an Individual Information Sheet (Form HP 1300.51.1) for each natural person named in any exhibit in Item F-1.

2. Contracts with Affiliated Persons, Principal Creditors and Providers of Administrative Services.

a. Persons to be Identified. Attach as Exhibit F-2-a a list identifying each individual or entity who is a party to a contract with applicant, if such contract is one for the provision of administrative services to the applicant or any such party is an Affiliated Person or Principal Creditor (Rule 1300.45(c) and (n)) or of the applicant. As to each such person, show the following information in columnar form:

(i) The names in alphabetical order.

(ii) The exhibit and page number of the contract (including loans and other obligations).

(iii) The type of contract or loan.

(e) Information Forms Required by Item F-1 of Subsection (b):

(1) Corporation Information Form.

STATE OF CALIFORNIA
DEPARTMENT OF CORPORATIONS

~~EXHIBIT-7-A-to-APPLICATION-FOR-HEALTH-PLAN-LICENSE-For-Corporations.~~

~~To-be-used-in-response-to-Item-7-of-Form-HP-1300.51.~~

EXHIBIT F-1-a-iii CORPORATION INFORMATION FORM

To be used in response to Item F-1-a of Form HP 1300.51.4.

1. Name of Applicant (as in Item ~~1~~-A D-1) _____

2. State of Incorporation 3. Date of Incorporation.

4. Is applicant a nonprofit corporation? ( ) Yes ( ) No

5. Is applicant exempted from taxation as a nonprofit corporation? ( ) Yes ( ) No

6. Names of principal officers, directors and shareholders. List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially over 5% of the voting securities of applicant or over 5% of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Relationship		Class of Equity	Percent
Last	First	Middle	Beginning Date Mo. Year	Title or Status	Security	of Class

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

(2) Partnership Information Form.

STATE OF CALIFORNIA
DEPARTMENT OF CORPORATIONS

~~EXHIBIT-7-B-to-APPLICATION-FOR-HEALTH-PLAN-LICENSE For-Partnerships. To-be-used-in-response-to-Item-7-of-Form-HP-1300.51.~~

1. Name of Applicant (as in Item A-~~1~~ D-1).

4. Provider Claims. Attach as Exhibit II-4 a statement describing applicant's system for processing claims from contracting providers and noncontracting providers for payment, and from subscribers and enrollees for reimbursement, including, the rules defining applicant's obligation to reimburse, the standards and procedures for applicant's claims processing system (including receipt, identification, handling, screening, and payment of claims), the timetable for processing claims, procedures for monitoring the claims processing system, and procedures for reviewing the claims processing system in view of compalints from contracting or noncontracting providers or grievances from subscribers or enrollees. The records maintained regarding fee-for-service reimbursements must be in accordance with the provisions of Rule 1300.77.4.

5. Other Business. If the applicant is or will engage in any business other than as a health care service plan, check here ( ) and attach as Exhibit II-5 a statement describing such other business, its relationship to applicant's business as a plan, and the anticipated financial risks and liabilities of such other business. If the financial statements and projections in Exhibits GG-1-a, GG-1-bb, HH-1 and HH-2 do not include such other business, explain.

(iv) Each relationship which such individual or entity bears to the applicant (officer, director, partner, trustee, member, Principal Creditor, employee, administrative services provider, health care services provider, or shareholder).

(v) Whether (yes or no) such individual or entity is intended to become a Principal Creditor (Rule 1300.45(n)) of applicant.

(vi) Whether (yes or no) such individual or entity is intended to become an "Affiliated Person" of applicant, or to become an Affiliated Person in any capacity other than that disclosed in item F-2-a-iv.

b. Copies of Contracts. Attach as Exhibit F-2-b a copy of each contract (other than a contract for the provision of administrative services or health care services furnished pursuant to Items K or N below) identified in Item F-2-a. Preceding the first page of each such contract, attach a summary sheet which (1) identifies the contract, (2) specified its terms, including its expiration date, and (3) if a loan or obligation, specified the unpaid balance of principal and interest and states whether applicant is in default upon the loan or obligation.

3. Other Controlling Persons. Does any individual or entity not named as a contracting party in Item F-2 or any exhibit thereto have any power, directly or indirectly, to manage, influence, or administer the operation, or to control the operations or decisions, of applicant?

( ) Yes ( ) No

If the appropriate response to this item is "yes", attach as Exhibit F-3-a a statement identifying each such person or entity and explaining fully, and summarizing every contract or other arrangement or understanding (if any) with each such person. (Each such contract should be submitted pursuant to Subsection F-2 or Subsection G-2, as appropriate.)

4. Criminal, Civil and Administrative Proceedings. Within the preceding 10 years, has the applicant, its management company, or any Affiliate of the applicant (Rule 1300.45(c)), or any controlling person, officer, director or other person occupying a principal management or supervisory position in such plan, management company or Affiliate, or any person intended to hold such a relationship or position, been convicted of or pleaded nolo contendere to a crime, or been held to have committed any act involving dishonesty, fraud or deceit in a judicial or administrative proceeding to which such person was a party?

( ) Yes ( ) No

If "yes", attach a spearate exhibit as to each such person designated Exhibit F-4, identifying such person and fully explaining the crime or act committed. Also, attach a copy of the exhibit for an individual to any Individual Information Sheet required by Item F-1-f for such individual.

5. Employment of Barred Persons. Has the plan engaged or does the plan intend to engage, as an officer, director, employee, associate, or provider, any person named in any order of the Commissioner pursuant to Section 1386(c) or Section 1388(d) of the Act?

( ) Yes ( ) No

II. Fiscal Arrangements.

1. Maintenance of Financial Viability. Attach as Exhibit II-1 a statement describing applicant's arrangements to comply with Section 1375.1(b) of the Act and Rule 1300.75.1(a)(2). If applicant will maintain insurance under these provisions, furnish a specimen of the policy, the name of the insurer and the premium cost to the policy.

2. Capitation Payments to Providers. If applicant intends to pay some or all providers on a capitation basis, attach as Exhibit II-2 a statement indicating the percentage of contracting providers who will be compensated on that basis, a description of the method used to determine and adjust the capitation rates, and substantiate by means of calculations or other information that such capitation rates are adequate to reasonable assure the continuance of the applicant/provider relationship.

3. Risk of Insolvency. Attach as Exhibit II-3 a description of the manner in which applicant will provide for each of the following in the event of applicant's insolvency:

a. The continuance of benefits to enrollees for the duration of the contract period for which payment has been made.

b. The continuance of benefits to enrollees until their discharge, for those enrollees confined in an in-patient health care facility on the date of insolvency.

c. Payments to noncontracting providers for services rendered.

a. Attach as Exhibit HH-6-a evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of furnishing health care services (malpractice insurance).

b. Attach as Exhibit HH-6-b evidence of adequate insurance coverage or self-insurance to respond to claims for tort claims, other than with respect to claims for damages arising out of furnishing health care services.

c. Attach as Exhibit HH-6-c evidence of adequate insurance coverage or self-insurance to protect applicant against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.

d. Attach as Exhibit HH-6-d, evidence of fidelity bond coverage for at least the amounts specified in Rule 1300.76.3, in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, providing 30 days' notice to the Corporation Commissioner prior to cancellation, and covering each officer, director, trustee, partner and employee of the plan, whether or not compensated.

e. Attach as Exhibit HH-6-e evidence of adequate workmen's compensation insurance coverage against claims which may arise against applicant.

If the appropriate response to this item is "yes", attach as Exhibit F-5 a statement identifying each such person and explaining fully.

G. Miscellaneous.

1. Consent to Service of Process. If applicant is not a California corporation, attach as Exhibit G-1 a Consent to Service of Process, in the form required by Rule 1300.51.2.

2. Disclosure of Financial Information. Attach as Exhibit G-2, authorizations for the disclosure of financial records of the applicant, and of any association, partnership or corporation controlling, controlled by or otherwise affiliated with the applicant pursuant to Section 1351.1 of the Act. (See Items F-3 and F-5).

H. Geographical Area Served.

Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.

An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan which does not meet these guidelines does not meet the requirement of reasonable accessibility.

c. If the ratio of total reimbursements to total expenditures in Item 4-a(viii) exceeds 10%, specify the measures by which applicant will comply with Section 1377(a) of the Act and Rules 1300.77 and 1300.77.3. If applicant will obtain insurance as specified in Section 1377(a)(1) of the Act, specify the size of the reserve and the fiscal impact upon applicant arising from its maintenance.

d. If the ratio of total reimbursements to total expenditures in Item 4-a(vii) exceeds 10%, specify the measures by which applicant will comply with Section 1377(b) of the Act and Rules 1300.77.1, 1300.77.2 and 1300.77.3.

5. Administrative Costs. If applicant's administrative costs (as defined in Rule 1300.78) as projected for its initial period of operation (as specified in the Note to Item CC and calculated pursuant to Item HH-2-e) exceed 25% of the prepaid or periodic charges paid by or on behalf of subscribers, and if such administrative costs exceed 20% of such charges for the following year, attach as Exhibit HH-5 a calculation of the percentage of administrative costs to such charges for both such periods and furnish information which explains the necessity for the level of administrative costs projected and the manner in which applicant will reduce such costs to not more than 15% of such charges within five years after licensure.

6. Provision for Extraordinary Losses.

The following requirements require an initial applicant to submit legible copies of the actual policies of insurance (including any riders or endorsements) or specimen copies of the policies of insurance which show all of the terms and conditions of coverage, or with respect to those items expressly allowing for self-insurance, allow applicant to provide evidence of self-insurance at least as adequate as insurance coverage.

4. Reimbursements. Attach as Exhibit HH-4 the following information regarding applicant's projected reimbursements:

a. Monthly and quarterly projections as specified in the note to Item CC for each of the following: (see instruction in Item 4-b):

(i) Payments to reimburse noncontracting providers for covered health care services furnished to enrollees (see Section 1377(a)).

(ii) Payments to reimburse enrollees for covered health care services furnished by noncontracting providers (see Section 1377(a)).

(iii) Total reimbursements for services by noncontracting providers -- (1) plus (2) (see Section 1377(a)).

(iv) Fee-for-service payments to reimburse contracting providers for covered health care services.

(v) Total reimbursements -- (3) plus (4).

(vi) Total expenditures by applicant for covered health care services.

(vii) The ratio of total reimbursements to total health care expenditures -- (5) divided by (6).

(viii) The ratio of reimbursements for services by noncontracting providers to total expenditures -- (3) divided by (6).

b. Describe and substantiate the facts and assumptions upon which the projections are based, including those for fee-for-service payments to contracting providers and document the source and validity of such assumption. (Acturial studies and other information furnished in response to these items).

(i) Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ration of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

(ii) Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

(iii) Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.

(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

1. Description of Service Area. As Exhibit H-1, attach a narrative description of the applicant's service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U. S. Postal Zip Code numbers included in the service areas. If the applicant has more than one service area, each service area should be separately described. To the extent possible, service areas should be delineated by political or natural boundaries. (If applicant uses sub-service areas or regions within its service areas for the purpose of allocating the provision of health care services by providers to enrollees, include that information in the description of the considerations which underlie the geographic distribution of the applicant's contracting and plan-operated providers.)

2. Map of Service Area. As Exhibit H-2, attach a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the acutal or projected enrollees live or work. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the state, such as are commonly available from automobile associations or retail service stations is preferred. The map or maps should show the following information:

a. Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.

b. The boundaries of applicant's service area.

e. as Exhibit HH-3-a the assumptions made by the applicant to determine the time lag between the delivery of covered health care services and applicant's payment for those services. Also indicate all other assumptions made in preparing the projected cash flow statements in Item HH-2-c.

f. Attach as Exhibit HH-3-f-i a detailed description of any measures taken or proposed to be taken by applicant to maintain compliance with the tangible net equity requirement under Rule 1300.76 and the financial viability requirement under Rule 1300.76.1 in view of losses and expenditures prior to reaching a break-even point in its operations. This information should include a schedule setting forth the amounts of any additional needed funding and the dates when such amounts will be infused into applicant. If such arrangements involve arrangements for additional capital, to subordinate or postpone the payment of accounts, notes or other obligations of the plan or other agreements, cite the exhibit numbers of such agreements and identify their applicable provisions, if supplied elsewhere in the application, or if not otherwise furnished, attach copies of such agreements or proposed agreements, identifying the parties thereto and their relationship to the plan and its affiliates.

If any funding is to be obtained from an entity other than a national bank or a bank incorporated under the laws of this state, attach as Exhibit HH-3-f-ii a copy of such entity's most recent annual audited and quarterly unaudited financial statements.

(i) Utilization rates for each medical expense item reflected in applicant's income statements furnished pursuant to Item HH-2, expressed in terms of utilization units per member per month, including the methodology and source of data used to determine such rates.

(ii) The cost per utilization unit for each medical expense item reflected in the income statement, including the methodology and source of data used to determine such costs.

(iii) The per member per month cost for each medical expense item.

(iv) The methodology and source of data used to estimate copayments, coordination of benefits, and reinsurance recoveries, including the expression of such items on a per member per month basis.

(v) Inflation estimates used in the projections and the source utilized to determine such estimates.

c. For each contract which is designated as experience rated (as summarized in Exhibit EE) attach as Exhibit HH-3-c an acturial report for the contract which conforms to the requirements stated in Item HH-3-b.

d. Attach as Exhibit HH-3-d a summary schedule which reflects the breakdown of the total revenue and expense included in the projected income statements in Exhibit HH-2-b by community rated contracts and experience rated contracts.

c. The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E".

d. The location of primary care providers, designated by a "P". For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.

e. The location of all other contracting or plan-operated health care providers including the following:

Dental, designated by a "D".

Pharmacy, designated by an "Rx".

Laboratory, designated by a "L".

Eye Care, designated by a "O".

Specialists and ancillary health care providers, designated by an "S".

f. The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan, designated by a "G". (See item CC-3)

3. Index to Map. As Exhibit H-3, attach an index to the map or maps furnished as Exhibit H-2 which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:

a. For each hospital, its total beds and the number of beds available to enrollees of the plan.

b. For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.

c. For each interested subscriber group, the name of the group and the projected number of enrollees from that group.

I. Description of Health Care Arrangements.

Note: Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements.

If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made.

However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network.

1. Physicians Services.

a. Individual Physicians. As Exhibit I-1-a list all individuals who provide covered physician services as employees of the plan or, whether directly or through an association or other entity, as contracting providers:

For each physician, furnish the following information.

(i) Name.

c. A calculation of applicant's projected tangible net equity in accordance with Rule 1300.76 as of the date specified in Item E and in accordance with its projected balance sheet.

2. Attach as Exhibit HH-2, projected financial statements as of the close of each month during applicant's initial period of operations, as defined in the note to Item CC, and as of the close of each quarter for the following year, prepared on a consistent basis with the financial statements furnished for Item HH-1, including the following:

a. Applicant's projected balance sheet as of the close of such month or quarter.

b. Applicant's projected statement of income and expense for such month or quarter.

c. Applicant's projected cash-flow statement for such month or quarter.

d. A calculation of applicant's tangible net equity pursuant to Rule 1300.76 as of such month or quarter.

e. A calculation of applicant's administrative costs pursuant to Rule 1300.78 for such month or quarter.

3. Furnish the following information to substantiate the assumptions and conclusions upon which the projections required by Items HH-1 and HH-2 are based:

a. Attach as Exhibit HH-3-a the complete results of feasibility studies obtained by applicant as normally required by conventional lending institutions, including at least the following: legal, marketing/enrollment, providers and financial.

b. Attach as Exhibit HH-3-b an actuarial report which includes at least the following information for all enrollees reflected in Exhibit EE as covered by contracts which are community rated:

b. If the financial statements attached as Exhibit GG-1-aa are for a period ended more than 60-days before the date of filing of this application, also attach as Exhibit GG-1-b financial statements prepared as of date no later than 60 days prior to the filing of this application consisting of at least a balance sheet, a statement of income and expenses, and any accompanying footnotes; these more recent financial statements need not be audited, so long as they are prepared in accordance with generally accepted accounting principles.

2. Tangible Net Equity. Attach as Exhibit GG-2 a calculation of applicant's tangible net equity in accordance with Rule 1300.76, based on the most recent balance sheet submitted as Exhibit GG-1-a or b above.

HH. Projected Financial Viability.

1. Attach as Exhibit HH-1, the following projected financial statements of the applicant reflecting actual and projected changes which have, or which are expected to occur between the date of its most recent financial statements furnished pursuant to Item GG and the date specified for the commencement of its operations as a plan in Item E above. The projected financial statements must be prepared in accordance with generally accepted accounting principles and on a basis consistent with the financial statements supplied in Item GG.

a. Applicant's projected balance sheet as of the start up date of the plan. (See item E)

b. Applicant's projected statement of income and expenses covering the period between the date of the most recent financial statements furnished in Item GG and the date specified in Item E.

(ii) License number.

(iii) Type of service as determined by board certification and eligibility. Primary care physicians should be designated as general practice, pediatrics, obstetrics, gynecology and internal medicine. Specialists should be designated as allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, onocology, opthalmology, orthopedics, pathology, psychiatry, radiology, surgeries, otolarynology, urology, and other designated as appropriate.

(iv) The plan-owned or contracting hospitals at which the physician has admitting staff privileges.

(v) The professional address of the physician.

(vi) The physician's relationship to the plan (employed by or contracting with the plan, or contracting through an IPA or one of the parties identified in Item I-1-a.

(vii) The percentage of the physicians time allocated to enrollees of the plan.

(viii) The business hours of the physicians office (i.e., Monday through Friday 8 - 5, closed Wednesdays).

b. Physician Associations. For all entities other than individuals or independent practice associations who contract with applicant to provide physician services, and each plan-operated facility at which physician services are rendered by employees of the plan, as Exhibit I-1-b furnish the following information for each such contractor or facility:

(i) The name of the contractor or facility.

(ii) The street address of the contractor or facility at which the physician services are rendered for the particular region or provider network.

(iii) The type of entity (professional corporation, sole proprietor, partnership, etc.).

(iv) The number of physicians rendering services for the plan by reason of such contract or by employment at such facility, and the number of "full-time equivalent" physicians being provided to enrollees of the plan.

2. Hospitals. Attach as Exhibit I-2 a list of all hospitals which are operated by or contract with the plan. Provide the following information for each hospital:

a. Its legal name and any dba.

b. Its address.

c. Its license number.

d. Whether it is a member of the American Hospital Association, whether it is currently accredited by the Joint Commission on the Accreditation of Hospitals, (JCAH) and the expiration date of its current accreditation.

e. Its bed capacity and rate of occupancy.

f. Its emergency room capabilities.

FF. Prepaid and Periodic Charges.

1. Determination of Prepaid Charges. Attach as Exhibit FF-1, a description of the method used by applicant to determine the prepaid or periodic charges fixed for individual and group contracts, including the method by which administrative and other indirect costs are allocated. Describe the facts and assumptions upon which such charges are based (e.g., contract mix, family size) and furnish supporting documentation to substantiate the validity of the facts and assumptions used.

2. Schedule of Prepaid Charges. Attach as Exhibit FF-2-a a complete schedule of the prepaid or periodic charges assessed subscribers under each group contract identified in response to Item P and attach as Exhibit FF-2-b a schedule of the prepaid or periodic charges assessed subscribers under each individual contract identified in response to Item Q.

3. Collection of Prepaid Charges. Attach as Exhibit FF-3 a description of the manner in which applicant will collect prepaid and periodic charges and copayments from subscribers and enrollees under its group and individual contracts. If prepaid or periodic charges will be paid by subscribers to an entity other than the plan, identify the entity and specify the measures used by the plan to safeguard and account for such funds (see Rules 1300.76.2, 1300.85 and 1300.85.1.)

FINANCIAL VIABILITY

GG. Current Financial Viability, including Tangible Net Equity.

1. Financial Statements.

a. Attach as Exhibit GG-1-a the most recent audited financial statements of applicant, accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant, together with all footnotes to said financial statements.

e. State whether the contract will be "community rated" or "experience rated".

f. Evaluation of the competition within the target area.

2. Substantiation of Projections. Attach as Exhibit DD-2 a statement of the facts and assumptions employed with respect to the information furnished for each contract and target population listed in Exhibit DD-1 and furnish documentation, including reliable market surveys, validating the facts and assumptions.

EE. Summary Enrollment Projections.

Attach as Exhibit EE summary enrollment projections on a monthly basis for the initial period specified in the note to Item CC and on a quarterly basis for the following year. Such enrollment projections should reflect the breakdown of enrollment by groups, individuals, Medi-Cal, Medicare, and others.

g. A list and full description of all services available to enrollees. Applicant may use a JACH form or the equivalent.

h. Its relationship with applicant (owned by, contracting provider, joint venture with applicant, etc.)

3. All Other Providers of Health Care Services. Attach as Exhibit I-3 a list of all providers of health care service contracting with or owned by the applicant which are not included in the physician and hospital listings. For each such provider, furnish the following information:

a. The legal name of the provider and any dba.

b. Its address.

c. Its license number.

d. The health care services it provides to enrollees of the plan (e.g., home health agencies, ambulance company, laboratory, pharmacy, skilled nursing facility, surgi-center, mental health, family planning, etc.).

e. Its hours of operation and the provision made for after-hours service.

f. An appropriate measure of the providers capacity to provide health care service, the existing utilization of such services by other than enrollees of the plan and the projected use of the services by enrollees.

g. The providers relationship to the plan (owned by, contracting with, etc.).

4. Calculation of Provider-Enrollee Ratios. As Exhibit I-4, furnish a calculation of the adequacy of the applicant's provider arrangements for each region or provider network within applicant's service area. This should be based on the full range of the health care services covered by the applicants full-service or specialized plan contracts, the extent to which contracting and planned owned or employed providers are available to provide such services, the enrollee population served by such providers and the adequacy of the provider system in each category based on standard utilization data. Assumptions employed in such calculations should be stated, including the extent to which paraprofessionals and allied health personnel will be used by applicant or providers and the protocols and method of supervision of such personnel.

5. Applicant's Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures for monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility which the applicant has as its objective and the minimum level of accessibility below which corrective action will be taken. Cover each of the following:

a. the availability of appointments for primary care and specialty services,

b. the availability of after hours and emergency services,

c. an assessment of probable patient waiting times for scheduled appointments,

g. State whether the contract will be "community rated" or "experience rated".

h. Evaluation of the competition for each group.

2. Substantiation of Projections. Attach as Exhibit CC-2 for each group contract specified in Exhibit CC-1 a description of the facts and assumptions used in connection with the information specified in that exhibit and include documentation of the source and validity of such facts and assumptions.

3. Letters of Interest. Attach as Exhibit CC-3 letters of interest or intent from each group listed in Exhibit CC-1, on the letterhead of the group and signed by its representative.

DD. Individual Contract Enrollment Projections.

1. Projections. Attach as Exhibit DD-1 a projection of applicant's sales of individual contracts for the periods specified in the note in Item CC above. Programs involving Medi-Cal, Medicare and Medicare supplemental coverages are to be treated as individual contracts. The exhibit is to contain the following information as to each type of individual contract:

a. A description (e.g., ethnic, demographic, economic, etc.) of each target population.

b. The estimated number of persons in each target population.

c. The distribution of the target population within and around applicant's service area.

d. The projected number of (1) subscribers and (2) enrollees (including subscribers) expected to be obtained from each target population, on a monthly basis for the initial period and quarterly for the following year.

CC. Group Contract Enrollment Projections.

Note: All projections required by Items CC, DD, EE and HH are to cover the period commencing from its commencement of operations as a licensed health care service plan until the applicant's financial statement projections under Item HH demonstrate that it has reached the break-even point (or for one year, whichever is longer) and for an additional period of one year thereafter. For the initial period, all projections are to be on a monthly basis. For the additional year, all projections are to be on a quarterly basis.

1. Projections. Attach as Exhibit CC-1 projections of applicant's enrollments under group contracts for the periods specified in the above note. (Medi-Cal, Medicare, and Medicare supplemental programs are to be treated as individual contracts under Item DD below.) Exhibit CC-1 is to contain the following information with respect to each anticipated group contract:

a. The name of the group.

b. The number of potential subscribers in the group.

c. The locations within and around applicant's service area in which the potential subscribers and enrollees live and work.

d. The estimated date (or period after licensing) for entry into the group contract.

e. Identification of the plan contract anticipated with the group, by reference to Exhibit P-1. If more than one type of group contract is expected with a group, each contract must be covered separately.

f. The projected number of (1) subscribers and (2) enrollees (including subscribers), on a monthly basis for the initial period specified in the above note and quarterly for the following year.

(d) the proximity of specialists, hospitals, etc. to sources of primary care, and

e. a description of applicant's system for monitoring and evaluating accessibility. (Discuss applicant's system for monitoring problems that develop, including telephone inaccessibility, delayed appointment dates, waiting time for appointments, other barriers to accessibility, and any problems or dissatisfaction identified through complaints from contracting providers or grievances from subscribers or enrollees.)

f. the contractual arrangements utilized by the applicant to assure the monitoring of accessibility and conformance to standards of accessibility by contracting providers.

6. Referrals. Attach as Exhibit I-6 a detailed description of applicant's system of documentation of referrals to physicians or other health professionals. Include:

a. the provisions made for written documentation of the referral policies and procedures,

b. the procedures for following up on contracting and noncontracting referrals, including turnaround times, and

c. applicant's arrangements for paying for services delivered by noncontracting providers.

J. Internal Quality of Care Review System.

Applicant is required to demonstrate that it has a system for the review of the quality of health care to identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization and the cost of services. The following

exhibits require a description and explanation of the system, including narrative, organization and process charts and review criteria. See Rule 1300.70.

1. Organization and Operation. As Exhibit J-1, furnish a description of the basic structure, organization and authority of the applicant's quality of care review system, including:

a. An organization chart showing the key persons, the committees and bodies responsible for the conduct of the review system, the provisions for support staff and the relationship of such persons, committees and bodies to the general organization of the plan. See Item J-4 below.

b. A narrative explanation of the review system covering the matters depicted in the organization chart and the following: the key persons involved, their titles and their qualification; the extent and type of support staff; the areas of authority and responsibility of the key persons and the committees, if divided among persons and committees; the frequency of meetings of the committees and the portion of their time devoted to the review system by key persons. See Item J-4 below.

2. Standards and Norms. Attach as Exhibit J-2 a description of the standards and norms of the system (including any measurement of deviation in their application), and indicate how these standards and norms will be communicated to providers.

3. Operation of System. Attach as Exhibit J-3 a description of the operation of the review system, including the frequency and scope of audits, the utilization of the audit results and the procedures and methods for the enforcement of the standard and norms of the system.

AA. Supervision of Marketing. Attach as Exhibit AA a statement setting forth applicant's internal arrangements to supervise the marketing of its plan contracts, including the name and title of each person who has primary management responsibility for the employment and qualification of solicitors, advertising, contracts with solicitors and solicitor firms and for monitoring and supervising compliance with contractual and regulatory provisions.

BB. Solicitation Contracts.

1. Attach as Exhibit BB-1 a list of all persons (other than any employee of the plan whose only compensation is by salary) soliciting or agreeing to solicit the sale of plan contracts on behalf of the applicant. For each such person, identify by exhibit number that person's contract furnished pursuant to Item BB-2 and, if such contract does not show the rate of compensation to be paid, specify the person's rate of compensation.

2. Attach as Exhibit BB-2, a copy of each contract or proposed contract between applicant and the persons named in Exhibit BB-1 for soliciting the sale of or selling plan contracts on behalf of applicant. If a standard form contract is used, furnish a specimen of the form, identify the provision and terms of the form which may be varied and include a copy of each variation.

3. If the rate of compensation for any solicitor or for any plan contract exceeds 5 percent of the prepaid or periodic charge for the contract(s) on an annual basis, attach as Exhibit BB-3 a statement explaining and justifying the rate of compensation in each such case.

d. specific identification of the [illegible] paragraph number of pertinent provisions of applicant's bylaws and/or other governing documents (as submitted in response to Item F) which set forth the procedures for public policy participation for subscribers and enrollees; and

e. the manner and frequency with which applicant will furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy and communicate material changes affecting public policy to subscribers and enrollees.

MARKETING OF PLAN CONTRACTS

Y. Marketing of Group Contracts. Attach as Exhibit Y a statement describing the methods by which applicant proposes to market group contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with Rules 1300.59, 1300.61, 1300.76.2, 1300.84.4 and 1300.85.1.

Z. Marketing of Individual Contracts. Attach as Exhibit Z a statement describing the methods by which applicant proposes to market individual plan contracts, including the use of employee or contracting solicitors or solicitor firms, their method or form of compensation and the methods by which applicant will obtain compliance with Rules 1300.59, 1300.61, 1300.76.2, 1300.84.4 and 1300.85.1.

4. Administration of System by Providers. If portions of the review system are administered by contracting providers, by affiliates of the applicant or by other persons who are not officers or employees of the applicant, attach Exhibit J-4 identifying those portions of the system together with the providers, affiliates or persons administering them on behalf of the applicant, and describe and furnish copies of the contractual provisions which assure the maintenance of the system to the standards of the applicant and those of the Act and the rules thereunder.

5. Monitoring of Provider Administration. Attach as Exhibit J-5, a description of the contractual arrangements which will be employed to enable the plan to monitor, and require, compliance with the quality of care review system, to the extent such system is administered by such contracting providers.

K. Contracts with Providers.

1. Copies of Contracts. Attach as Exhibit K-1 a copy of each contract made, or to be made, between applicant and each provider of health care services. If a contract shows the payment to be rendered a provider, delete such minimum portion of the contract as is necessary to prevent disclosure of such information, by blanking out or other suitable means.

a. If standard form contracts are used, only a specimen of each type of form contract need be filed together with any variations to be used in the terms and provisions of such standard forms, other than in the amount of payments to providers.

b. The contracts and other information submitted in this exhibit will be available for public inspection (see Section 1351(d)).

2. Compliance with Requirements. Attach as Exhibit K-2 a statement in tabular form for each provider contract, and for each standard form contract and its variations, if any, specifying the provisions of such contract which comply with the following provisions of the act and rules:

Section 1379

Rule 1300.67.1(a) and (c)

Rule 1300.67.2 (b), (c) and (f)

Rule 1300.67.4(a)(9) and (10)

Rule 1300.67.8(a), (b), (c) and (d)

Rule 1300.68

Rule 1300.70

Rule 1300.51, Item J-5

3. Compensation of Health Care Providers. Attach as Exhibit K-3 one copy of the following provisions from each provider contract, or proposed provider contract, from which payment information was deleted in Exhibit K-1 and clearly mark the extracts from each contract "confidential":

a. The title page of the contract or other information sufficient to identify the contract submitted as Exhibit K-1 to which the extract relates and the providers who are parties.

b. The effective date of the contract and its expiration date.

c. The provisions describing the mechanism by which payments are to be rendered to the provider, including any risk sharing arrangement, clearly identified by the name of the provider.

d. The provider's signature on the execution page of the contract, with the name of the provider typed beneath the signature.

X. Public Policy Participation.

1. If applicant is in compliance with the requirements of the federal Health Maintenance Organization Act of 1973 and intends to rely on such compliance to satisfy the provisions of Section 1369 of the Act, attach as Exhibit X-1 documentation necessary to validate compliance with the Health Maintenance Organization Act.

2. Unless applicant has satisfied the provisions of Section 1369 of the Act in the manner indicated in Subsection X-1, above, attach as Exhibit X-2 a description of applicant's procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan, including at least the following:

a. the composition of applicant's governing board,

b. the composition of the standing committee established which shall participate in establishing the public policy of the plan as defined in Section 1369 of the Act, the frequency of said committee's meetings, the frequency of receipt by applicant's governing body of said committee's reports and recommendations, and the procedures established by the governing body for dealing with such reports and recommendations;

c. the means by which subscribers and enrollees participating in established public policy will be given access to information and information regarding the specific nature and volume of complaints received by applicant and their disposition;

V. Advertising. Attach as Exhibit V a copy of any adverting which is subject to Section 1361 of the Act and which applicant proposes to use. With respect to each proposed advertisement indicate the contract(s) by name and by exhibit number(s) to which said advertisement relates and identify the segment of the public to which the advertisement is directed.

W. Enrollee/Subscriber Grievance Procedures.

1. Attach as Exhibit W-1 a copy of its written grievance procedure adopted or to be adopted by applicant to comply with all of the provisions of Section 1368 of the Act and Rules 1300.68, 1300.85 and 1300.85.1.

2. Attach as Exhibit W-2, copies of the complaint forms and the written explanation of its grievance procedure which the plan will make available to enrollees and subscribers.

3. If the written procedure furnished as Exhibit W-1 does not identify the key personnel of applicant and provider organizations that will be responsible for carrying out its grievance procedures and the review of its results, attach Exhibit W-3 giving the name and title of each such person and identifying their responsibility for carrying out the procedure.

L. Organization Chart.

Attach as Exhibit L an organization chart which shows the lines of responsibility and authority in the administration of the applicant's business as a health care service plan. One chart should be furnished for the applicants, showing its management and operational structure, including the names and titles of key positions and its board. The chart should show the total management structure of the business in all areas, and including the key positions and departments of the applicant and those in any affiliate and/or contracting provider of health care and/or administrative services, including but not limited to the particular management functions required in the administration of a health care delivery system. The charts are to show the names of the corporations, partnerships and other entities involved in such administration, their boards, committees, and key management positions involved, giving the names of the boards, committees and positions and the persons serving therein.

M. Narrative Information.

1. Attach as Exhibit M-1 a narrative explanation of the organization chart, including the responsibility and authority of each entity, board, committee and position and identifying the persons who serve on such boards and committees and in such positions.

2. Attach as Exhibit M-2, a statement as to each individual who is a member of a board or committee or who occupies a position specified in Exhibit L and Exhibit M-1, covering the following:

a. Name.

b. Each position (e.g., director, officer, committee member, key management personnel and the managers of key departments) such person holds which is indicated in Exhibits L and M-1, whether with applicant, an affiliate or a contracting provider of health, administrative or other services. Also state the person's principal responsibilities and authority in each position, and the portion of the individual's time devoted to each principal function.

c. A resume or similar description of such person's training and experience during the preceding five years (or longer, if desired) which are relevant to the duties and responsibility in applicant's business as a health care service plan.

N. Contracts for Administrative Services.

1. As Exhibit N-1, attach a copy of each contract which applicant has for administrative or management services, or consulting contracts, or which applicant intends to have for the Health Plan.

2. As Exhibit N-2, describe applicant's administrative arrangements to monitor the proper performance of such contracts and the provisions which are included in them to protect applicant, its plan business and its enrollees and providers in the event there is a failure of performance or the contract is terminated.

O. Attach as Exhibit O a statement describing how the Health Plan organization will provide for separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management. Describe what controls will be put

Section 1345 (definitions)	Rule 1300.63(a)(1)
1362 (definitions)	1300.63.1(b)(1) and (2)
	1300.62.2(b)(1) and (2)
	1300.63.2(c)(1) through (16)
	1300.69(i)

U. Combined Evidence of Coverage and Disclosure Forms.

Applicant may combine the evidence of coverage and disclosure form into one document if it complies with each of the requirements set forth in Rule 1300.63.2.

1. Attach as Exhibit U-1 a copy of each combined evidence of coverage and disclosure form. Each combined evidence of coverage and disclosure form should relate to one form of plan contract; however, a combined evidence of coverage and disclosure form offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

2. Attach as Exhibit U-2 a statement in tabular form for each combined evidence of coverage and disclosure form submitted as Exhibit U-1 above, the section, paragraph or page number which shows compliance with each of the following sections of the Act or Rules (following the parenthetical instructions as set forth in the note immediately preceeding Item P above, if there are multiple combined evidences of coverage and disclosure forms):

Section 1345 (definitions)	Rule 1300.63.2(b)(1) and (2)
1362 (definitions)	1300.63.2(c)(1) through (27)
	1300.69(i)

2. Attach as Exhibit S-2 a statement in tabular form for each disclosure form submitted as Exhibit S-1 above, identifying the section, paragraph, or page number of the disclosure form which shows compliance with each of the following sections of the Act or rules (following the parenthetical instructions set forth in the note immediately preceding Item P above, if there are multiple disclosure forms):

Section 1345 (definitions)	Rule 1300.67(a)(1)
1362 (definitions)	1300.63(b)(1) through (14)
1363(a)(1) through (8)	
1363(a)(10)	
1373(g) (if disclosing group contract)	

T. Evidence of Coverage.

1. Attach as Exhibit T-1 a copy of each evidence of coverage which applicant proposes to use. Each evidence of coverage should relate to one form of plan contract which must be identified by name and by exhibit number; however, an evidence of coverage for alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract and if the alternative contracts are clearly identified by name or exhibit number.

2. Attach as Exhibit T-2 a statement in tabular form for each evidence of coverage submitted as Exhibit T-1 above, the section, paragraph, or page number of the evidence of coverage which shows compliance with each of the following sections of the Act or rules (following the parenthetical instructions set forth in the note immediately preceeding Item P above, if there are multiple evidences of coverage):

into place to assure compliance with this requirement. Refer to appropriate items in Exhibit "J", Internal Quality of Care Review System.

SUBSCRIBER CONTRACTS, DISCLOSURES, AND RELATIONS

Note: In Items P and Q, the applicant is required to include as exhibits copies of the health care service contracts it will issue, including standard form contracts and any variations in the provisions of those forms. In addition, the applicant is required to identify the particular provisions of these contracts which comply with the provisions of the Act and rules listed at the end of this note, or which vary from those provisions. The applicant is also required to explain its proposed variations (if any) from the Act or rules, giving the reasons and justifications for such variances.

The provisions of the Act and rules required to be covered in the information furnished pursuant to Items P and Q are the following:

All Plan Contracts

Section 1345 (definitions)	Rule 1300.45 (definitions)
1362 (definitions)	1300.63(a)(only if used
1363 (only if used for	as evidence of coverage)
evidence of coverage)	1300.63.1 (only if used
1365	as evidence of coverage)
1367.6	1300.63.2 (only if used as
1367.8	evidence of coverage)
1373	1300.67.4
1373.4	1300.68(b)

Group Contracts Only

Section 1367.2
1367.3
1367.5
1367.7
1373.1
1373.2
1373.5
1373.6
1374
1374.10

P. Group Health Care Service Plan Contracts.

1. Copies of Contracts. Attach as Exhibit P-1 a copy of each group contract which is to be issued by applicant. With respect to contracts based on a standard form, only a specimen of each standard form need be submitted, accompanied by Exhibit P-2.

2. Variations in Standard Form. Attach as Exhibit P-2, if applicant uses standard form group contracts, a schedule or explanation of the variations which will be made in the terms and provisions of such contracts when issued. If no variations will be made, so state.

3. Compliance with Requirements. Attach as Exhibit P-3 a schedule in tabular form for each group contract and each standard form group contract, identifying the particular provision of such contract which complies with each relevant provision of the Act and the rules listed in the preface note to this part, covering also any variations made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit P-3 and furnish Exhibit P-4.

4. Variance with Requirements. As Exhibit P-4, attach a statement with respect to each variance which the applicant proposes to make from the Act or rules in its group contracts, indicating the reasons for the variance and, if applicable, the circumstances under which the variance from the Act or rules is proposed to be used.

Q. Individual Health Care Service Plan Contracts.

1. Copies of Contracts. Attach as Exhibit Q-1 a copy of each individual contract which is to be issued by applicant. With respect to contracts based on a standard form, only a specimen of each standard form need be submitted, accompanied by Exhibit Q-2.

2. Variations in Standard Form. Attach as Exhibit Q-2, if applicant uses standard from individual contracts, a schedule or explanation of the variations which will be made in the terms and provisions of such contracts when issued. If no variations will be made from the standard form, so state.

3. Compliance with Requirements. Attach as Exhibit Q-3 a schedule in tabular form for each individual contract and each standard form individual contract, identifying the particular provision of such contract which complies with each relevant provision of the Act and the rules listed in the preface note to this part, covering also any variations to be made in standard form contracts. As to any provision which varies from the applicable provision of the Act or rules, identify such provision in Exhibit Q-3 and furnish Exhibit Q-4.

4. Variance from Requirements. As Exhibit Q-4, attach a statement with respect to each variance which the applicant proposes to make from the Act or rules in its individual plan contracts, indicating the reasons for the variance and, if applicable, the circumstances under which the variance from the Act or rules is proposed to be used.

R. (Reserved for future use).

S. Disclosure Forms.

1. Attach as Exhibit S-1 a copy of each disclosure form which applicant proposes to use, and identify by name and by exhibit number the contract or contracts in Exhibit P-1 or Q-1 with which the disclosure form will be used. If the disclosure form vary in text, format and arrangement in a manner which may make it difficult to identify and compare alternatives and their effect upon the contract, include an explanation which indicates how such difficulties will be avoided.

REPORT UNDER CHAPTER 830, STATUES 1983, AS OF DECEMBER 30, 1983

Section 3 of Chapter 830 of the Statutes of 1983 ("Chapter 830"), effective September 14, 1983, requires the Department of Corporations and the Department of Insurance, to report to the Chairmen, respectively, of the Senate Insurance, Claims and Corporations Committee, and the Assembly Finance and Insurance Committee, detailing the effectiveness of the enforcement of Chapter 830. Accordingly, the Department of Corporations submits this report detailing the effectiveness of its enforcement of Chapter 830 and covering the period beginning September 14, 1983, the effective date thereof, and ending December 30, 1983.

Chapter 830 added Section 1346.5 to the Health and Safety Code, and amended Section 740 of the Insurance Code. This Department defers to the Department of Insurance ("DOI") with respect to DOI's enforcement of Section 740 of the Insurance Code, and confines this report to this Department's enforcement of Section 1346.5 of the Health and Safety Code.

I. REFERRALS TO DOI.

Section 1346.5 requires that if the Commissioner determines that an entity purporting to be a health care service plan ("HCSP") exempt from the provisions of Section 740 of the Insurance Code is not an HCSP, the Commissioner shall inform DOI of that finding.

Upon enactment of Section 1346.5, this Department formalized its existing procedures pursuant to which information is forwarded to DOI regarding unregulated entities which this Department has concluded are not HCSPs and may be of interest to DOI. This Department has also implemented recordkeeping procedures to insure that those referrals to DOI which are mandated by Section 1346.5 are counted for the purposes of this Department's report pursuant to Section 3 of Chapter 830.

Based upon the above procedures and during this reporting period, the Commissioner has not determined that an entity purporting to be an HCSP exempt from the provisions of Section 740 of the Insurance Code is not an HCSP, and, accordingly, has not had an occasion to inform DOI of such a finding.

II. REFERRALS FROM DOI.

Section 740 of the Insurance Code, as amended by Chapter 830, requires DOI to notify, in writing, the Commissioner of Corporations whenever it determines that a multiple employer trust qualifies as an HCSP subject to the Knox-Keene Health Care Service Plan Act.

Upon the enactment of Section 1346.5, this Department formalized its existing procedures pursuant to which referrals are received from DOI regarding entities which DOI considers to be HCSPs subject to the Knox-Keene Act. This Department has also implemented recordkeeping procedures to insure that those referrals received from DOI which are mandated by Section 740 of the Insurance Code are counted for the purpose of this Department's report pursuant to Section 3 of Chapter 830.

Based upon the above procedures and during this reporting period, the Commissioner has no records of having received from DOI any referrals mandated by Section 740 of the Insurance Code.

III. ESTABLISHMENT AND MAINTENANCE OF LIST PURSUANT TO SECTION 1346.5.

Section 1346.5 requires that if the Commissioner determines that an entity is an HCSP, the Commissioner shall prepare and maintain for public inspection a list of those persons or entities described in Section 740(a) of the Insurance Code, which are not subject to the jurisdiction of another agency of this or another state or the federal government and which the Commissioner knows to be operating in this state.

Accordingly, the Commissioner has established and maintains the required list pursuant to the criteria set forth in Section 1346.5:

(a) the Commissioner has determined that the person or entity is an HCSP;

(b) the person or entity is described in Section 740(a) of the Insurance Code;

(c) the person or entity is not subject to the jursdiction of another agency of this or another state or federal government;

(d) the Commissioner knows that the person or entity is operating in this state.

In order to maintain fidelity to Section 1346.5, the Department has established procedures pursuant to which, in each particular case, it is determined whether a person or entity satisfies the four statutory criteria. If and when it is determined that a person or entity satisfies all four of the mandated criteria, the name of the person or entity is added to the list maintained pursuant to Section 1346.5. If it is determined that a person or entity fails to satisfy one or more of the statutory criteria, information regarding such person or entity is nevertheless retained and subsequently reviewed to determine whether any additional information, secured through enforcement investigation or otherwise, results in the satisfaction of the four statutory

criteria as to such person or entity at a later date. If and when that occurs, the name of such person or entity is added to the list at that time. However, in many cases, a person or entity initially failing to satisfy all of the statutory criteria will never be added to the Section 1346.5 list. For example, if the first three elements are satisfied as to a person or entity which has already been closed due to enforcement action of the Department, the person or entity cannot be included on the list under Section 1346.5 because the Commissioner cannot then purport to know that the person or entity is operating in this state.

In addition to those entities which are not included on the list for failure to satisfy one or more of the criteria set forth in Section 1346.5, it is noted that those HCSPs which possess a currently effective license under the Knox-Keene Health Care Service Plan Act are also not included on the list maintained pursuant to Section 1346.5.

A copy of the Department's current list maintained pursuant to Section 1346.5 is attached as APPENDIX ONE. The Department's list is to be updated as necessary and no less often than quarterly.

IV. OTHER ACTIVITIES ENFORCING SECTION 1346.5.

Section 1346.5 also requires that any solicitor licensed by this Department who advertises or solicits HCSP coverage in this state described in Section 740(a) of the Insurance Code, which is provided by any person or entity described in Section 740(c), and where such coverage does not meet all pertinent requirements specified in the Insurance Code, and which is not provided or completely underwritten, insured or otherwise fully covered by an HCSP, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of plan coverage.

While these provisions of Section 1346.5 do not impose any express duty upon this Department, the Department has nevertheless implemented those provisions by publishing a release to solicitors and solicitor firms to advise them of the existence and significance of these provisions. It is the Department's belief that Release 14-H, a copy of which is attached as APPENDIX TWO, will assist solicitors and solicitor firms in complying with the duties imposed upon them by these provisions, and, as a result, will benefit persons who indicate an interest in the persons or entities at which Section 1346.5 is directed.

In conclusion, therefore, the Department considers its enforcement of those provisions of Chapter 830 which pertain to it to be effective. However, due to the relatively short period of time since its enactment, it is anticipated that considerably more data relative to the enforcement of Chapter 830 will be available for inclusion in the Department's report for the period ending December 31, 1983 than is available at this time.

APPENDIX ONE

PERSONS OR ENTITIES DETERMINED TO BE HEALTH CARE SERVICE PLANS NOT SUBJECT TO THE JURISDICTION OF ANOTHER AGENCY OF THIS OR ANOTHER STATE OR THE FEDERAL GOVERNMENT AND WHICH THE COMMISSIONER OF CORPORATIONS KNOWS TO BE OPERATING IN THIS STATE, AS OF DECEMBER, 1983

This list is maintained pursuant to Section 1346.5 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act"), which requires the Commissioner of Corporations to maintain for public inspection a list of those persons or entities which are health care service plans, which are described in Section 740(a) of the Insurance Code, which are not subject to the jursidiction of another agency of this or another state or the federal government, and which the Commissioner knows to be operating in this state. This list does not include health care service plans which are licensed by the Commissioner; information regarding licensees may be secured by telephoning (213) 736-3131.

This list is to be updated at least quarterly and more frequently as may be necessary. There shall be no liability of any kind on the part of the state, the Commissioner, and the employees of the Department of Corporations for the accuracy of the list or for any comments made with respect to it.

Air Evac International, Inc.

American Dental Centers

(II) California Dental Health Plan

Concept-100 Health Care Systems

Health Maintenance Associates, Inc.

Inland Valley Senior Services Club

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

George Deukmejian,
Governor

Franklin Tom,
Commissioner of Corporations

DATE December 9, 1983

RELEASE No. 14-H

SOLICITORS AND SOLICITOR FIRMS ADVERTISING OR SOLICITING FOR HEALTH PLANS SUBJECT TO SECTION 1346.5 OF THE HEALTH AND SAFETY CODE

Solicitors and solicitor firms within the meaning of Section 1345 of the Knox-Keene Health Care Service Plan Act ("Act") may not legally advertise or solicit for entities providing health care coverage unless the solicitor or solicitor firm complies not only with the ongoing regulatory requirements imposed on solicitors and solicitor firms by the Act but also with the new research and disclosure requirements imposed by Section 1346.5 of the Act as added by Chapter 830, Stats. 1983 (AB 160, effective September 14, 1983).

The purpose of Chapter 830, Stats. 1983 is to protect consumers from unknowingly assuming the risks associated with securing health care coverage from entities which operate in apparent violation of state regulatory requirements. Often such entities falsely purport to be multiple employer trusts subject to the federal Employee Retirement Income Security Act ("ERISA") in order to delay enforcement actions by this Department or the Department of Insurance by falsely claiming federal preemption under ERISA. Even though an ERISA preemption defense may later be proved in court to be inapplicable, an entrepreneurial group which can delay action by state regulators long enough to earn substantial sums of money will have bettered itself financially at the expense of unwitting employers and employees who often do not suspect that the entity providing coverage may be seriously substandard. If such an entity is undercapitalized, the losers are the employees who may discover that the entity sooner or later is unable to respond to their requests for services or claims for imbursement. Such an impasse can result in embarassment and roblems for the employer/employee group sponsor and in serious inancial hardship to subscribers and their families.

To protect consumers from dealing without full disclosure with entities operating in apparent violation of state licensure requirements before those entities can be subjected to state regulation or closed down for illegal operations, due to inevitable delays relating to due process, administrative hearing and court rules and calendaring, the Legislature has imposed certain duties of research and disclosure upon any solicitor or solicitor firm advertising or soliciting for such an entity.

Prior to advertising or soliciting any health plan coverage, a solicitor or solicitor firm must determine whether such coverage is provided by a health care service plan licensed by this Department or an insurer regulated by the Department of Insurance or an entity which is able to show that it is subject to the jurisdiction of some other state or federal agency, for example, by producing an official opinion letter of the federal Department of Labor. If the health coverage is not provided or fully covered by a health care service plan regulated by this Department, or by an entity regulated by the Department of Insurance, or by an entity which is able to show that it is subject to the jurisdiction of another state or federal agency, the solicitor or solicitor firm is required to advise and disclose to any purchaser, prospective purchaser, covered person or entity, all financial and operational information related to the content and scope of the plan, and specifically, as to the lack of plan coverage. (See Section 1346.5 of the Health and Safety Code and Section 740 of the Insurance Code).

This Department maintains a roster of health care service plans which are licensed under the Act. The Department of Insurance maintains records indicating the insurers which are authorized to engage in a business as an insurer in this state. Solicitors and solicitor firms may contact this Department and the Department of Insurance to determine whether an entity for whom they have been requested to advertise or solicit is regulated by the respective Department. If an entity is not regulated by this Department or the Department of Insurance, the solicitor or solicitor firm should immediately consult the lists discussed below.

Section 1346.5 of the Health and Safety Code, as enacted by Chapter 830, Stats. 1983, requires this Department to maintain a list of persons or entities which are health care service plans, are described in Section 740(a) of the Insurance Code, are not subject to the jurisdiction of another agency of this or another state or the federal government, and are known by the Commissioner to be operating in this state. Section 740 of the Insurance Code requires the Department of Insurance to maintain a similar list with respect to the entities subject to that section. While this Department's list and the Department of Insurance's list will assist solicitors and solicitor firms in carrying out their duty of research, the Commissioner does not consider a solicitor or

solicitor firm's duty of research to be fulfilled merely by virtue of consulting such lists.

Questions regarding the current status of any health plan or other entity may be directed to this Department at (213) 736-3104. However, the Commissioner recommends that any solicitor or solicitor firm wishing to advertise or solicit for any entity not regulated by this Department or the Department of Insurance first seek the opinion of an active member of the State Bar of California regarding the nature and scope of said solicitor or solicitor firm's duty of research and disclosure. The information contained in this release is for informational purposes only, does not constitute such legal advice, and cannot be relied upon for the purposes of defending against any action of this Department, the Department of Insurance, or any other party.

FRANKLIN TOM
Commissioner of Corporations

By
ROBERT E. LA NOUE
Assistant Commissioner
Office of Policy

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

George Deukmejian,
Governor

Franklin Tom,
Commissioner of Corporations

DATE December 9, 1983

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-over-

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Questions regarding the current status of any health plan or other entity may be directed to this Department at (213) 736-3104. However, the Commissioner recommends that any solicitor or solicitor firm wishing to advertise or solicit for any entity not regulated by this Department or the Department of Insurance first seek the opinion of an active member of the State Bar of California regarding the nature and scope of said solicitor or solicitor firm's duty of research and disclosure. The information contained in this release is for informational purposes only, does not constitute such legal advice, and cannot be relied upon for the purposes of defending against any action of this Department, the Department of Insurance, or any other party.

FRANKLIN TOM
Commissioner of Corporations

By 
ROBERT E. LA NOUE
Assistant Commissioner
Office of Policy

DOC 1775 12/83 by DOC LA 0782

STATE OF CALIFORNIA—BUSINESS AND TRANSPORTATION AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CORPORATIONS
1025 P STREET, Room 205
SACRAMENTO, CALIFORNIA 95814
(916) 445-7205

IN REPLY REFER TO:

FILE NO. OP 4664H

WLB

COMMISSIONER'S OPINION

THIS INTERPRETIVE OPINION IS ISSUED BY THE COMMISSIONER OF CORPORATIONS PURSUANT TO SECTION 1344(b) OF THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. IT IS APPLICABLE ONLY TO THE TRANSACTION IDENTIFIED IN THE REQUEST THEREFOR, AND MAY NOT BE RELIED UPON IN CONNECTION WITH ANY OTHER TRANSACTION.

Thomas C. Geiser
Hanson, Bridgett, Marcus, Vlahos & Stromberg
333 Market Street, Suite 2300
San Francisco, California 94105

Dear Mr. Geiser:

This request for an interpretive opinion, contained in the letter of Ross E. Stromberg dated May 12, 1983, as supplemented by your letters dated May 18, 1983, June 16, 1983, and June 22, 1983, and the materials submitted therewith, has been considered by the Commissioner. These letters raise the question whether the Providers' Network of Orange and Los Angeles, Inc., doing business as Preferred Health Network ("PHN"), and/or the Saddleback Valley Medical Group, Inc., a California professional medical corporation ("Medical Group"), is a health care service plan within the meaning of Section 1345(f) and subject to the licensure requirement of Section 1357 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").

You have represented that PHN is to be owned and governed by equal numbers of nonprofit hospitals and physician provider organizations ("Professional Practice Groups") comprised of physicians who are members of the medical staffs of those hospitals. PHN is developing a network ("PHN Network") of licensed hospitals, professionals and facilities (collectively, "Health Care Providers") which are willing to enter individual selective contracts with insurers and other third persons responsible for the payment of health care costs (collectively, "Payors").

Hospitals will become participants in the PHN Network by entering into Participation Agreements directly with PHN. In the case of physicians, Professional Practice Groups will enter into Participation Agreements directly with individual physicians, and the Professional Practice Groups will enter into Participation Agreements with PHN. Physicians who are participants in a

Professional Practice Group which has entered into a Participation Agreement with PHN become participants in the PHN Network. Payors who wish to participate in the PHN Network will enter into Participation Agreements directly with PHN.

The services of participating Health Care Providers will be marketed by PHN to participating Payors. PHN and Professional Practice Groups such as Medical Group function principally to bring together individual participating Payors and individual participating Health Care Providers, and those parties will then negotiate independently and enter into agreements for the provision of health care services ("Services Agreements") to persons for whose health care services a Payor is under an obligation to provide or otherwise arrange, or to pay, or whom a Payor is under an obligation to indemnify for the cost of those services ("Beneficiaries"). PHN anticipates that participating Payors will make available to certain of their Beneficiaries the option of either securing services from Health Care Providers participating in the PHN Network at certain costs or securing such services from other sources by paying certain additional amounts or pursuant to different terms and conditions, thereby giving the Beneficiaries an economic incentive to use the services of participating Health Care Providers. PHN does not anticipate any involvement by the PHN Network in "exclusive provider" arrangements whereby Beneficiaries would be required to utilize the services of participating Health Care Providers.

PHN is developing utilization review, quality assurance and Beneficiary services programs designed to encourage the provision of high quality care to Beneficiaries at competitive costs. The proposed Beneficiary services program is designed to make PHN representatives available to Beneficiaries to hear complaints and refer them to Payors for resolution. The proposed utilization review and quality assurance programs will operate to review and monitor the nature and quality of services provided by participating Health Care Providers. While Professional Practice Groups generally will not be parties to Services Agreements and will not undertake to provide health care services to Beneficiaries, they will, through contractual agreements, perform certain of the professional medical and other duties related to the utilization review, quality assurance and Beneficiary services programs. A failure to comply with the terms of the utilization review and quality assurance progams may result in termination of a PHN Network participant's Participation Agreement.

It is anticipated that the contracting process offered by the PHN Network will be effected through and in accordance with certain uniform provisions, reflected in the Standard Terms and Conditions, which will be incorporated by reference in the

Participation Agreements and Services Agreements. The Participation Agreements serve to bring Payors, Professional Practice Groups and Health Care Providers into the PHN Network. The Services Agreements will take the form of offers made by individual Payors to individual Health Care Providers qualified to render the services requested. The offers are to set forth the health care services requested by the Payor and the hospital charge or professional fee that the Payor offers to pay for those services. Offers received may be accepted, rejected or negotiated between participating Payors and Health Care Providers; PHN and Medical Group will not be parties to such negotiations. Upon acceptance, the offers become Services Agreements. Offers to hospitals and other health care facilities will generally be transmitted by PHN from Payors to the entities to which they are directed. In the case of offers to physicians and other health care professionals, the offers will generally be transmitted from Payors to PHN, which will transmit them to the various Professional Practice Groups. The Professional Practice Groups will in turn transmit the offers to the physicians and other health care professionals to whom they are directed. Offers received may be accepted, rejected or negotiated by individual offerors and offerees; PHN and Medical Group will not be parties to these negotiations. Upon acceptance, the offers become Services Agreements. Services to be provided and price terms and terms affecting price of Services Agreements are to be determined only by individual Payors and individual Health Care Providers. The acceptance or rejection of any offer for the performance of health care services by a Payor to a particular Health Care Provider is a matter solely within the discretion of that Health Care Provider. PHN, the Professional Practice Groups and Health Care Providers that are participants in the PHN Network are not authorized or appointed as the agent of any Health Care Provider that is a participant in the PHN Network for purposes of accepting, rejecting or negotiating the price terms or terms affecting price of any offer or agreement between a Payor and any other Health Care Provider that is a participant in the PHN Network.

PHN will receive an administrative fee from Payors. PHN intends to apply fee proceeds to its operating expenses, including its expenses in administering the utilization review, quality assurance and Beneficiary services programs and to its expenses in compensating entities such as Medical Group for their services rendered in connection with those programs. Two alternative methods may be used to determine the administrative fee to be paid to PHN: the fee may be a set percentage of an aggregate of charges paid by participating Payors to participating Health Care Providers for health care services performed, or it may be calculated as a figure based on the Beneficiary census per month for participating Payors (i.e., the number of Beneficiaries to whom a Payor is making available the servies of participating Health Care Providers).

Neither PHN nor Medical Group will be involved in the financing or claims administration of any health care programs offered by Payors to their Beneficiaries. PHN and Medical Group will not be responsible for billing or collection, and they will not bear any economic risk related to the delivery of health care services to the Beneficiary of Payors. Once Services Agreements have been entered into between Payors and Health Care Providers, the involvement of PHN and Medical Group will be limited to operation of the utilization review, quality assurance and Beneficiary services programs. PHN and Medical Group will not undertake the marketing of any plans for the provision of health care services to the Beneficiaries of any Payor.

Section 1345(f) of the Act defines "health care service plan" to include any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees. Section 1399.5 provides that the Act shall be applicable to any private or public entity or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, unless such entity is exempted from the provisions of the Act by, or pursuant to, Section 1343. Section 1349 of the Act provides that it is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the Commissioner a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder.

Initially it is necessary to consider whether Medical Group is a health care service plan within the meaning of Section 1345(f). In this connection, you have represented that Medical Group is not to receive a fee from Payors. While Medical Group is to be compensated by PHN for services rendered by Medical Group in connection with the utilization review, quality assurance and neficiary services programs of PHN, you have represented that e compensation paid to Medical Group is to be based on the value f the services actually performed by Medical Group rather than aid on a prepaid or periodic basis. Accordingly, based on the epresentations contained in the letters and materials referred to above, it is our opinion that Medical Group does not receive a prepaid or periodic charge paid by or on behalf of subscribers or enrollees within the meaning of Section 1345(f), and, accordingly, is not a health care service plan subject to the licensure requirement of Section 1349 of the Act.

It remains to be determined whether PHN is a health care service plan within the meaning of Section 1345(f). In this connection, you have represented that PHN is to receive a fee from Payors. The "administrative fee" paid by Payors to PHN is to be either a set percentage of an aggregate of charges paid by Participating Payors to participating Health Care Providers for services rendered to Beneficiaries or a figure based on the monthly Beneficiary census of participating Payors. In our view, such a fee constitutes a prepaid or periodic charge paid to PHN by or on behalf of subscribers or enrollees within the meaning of Section 1345(f) of the Act. That no part of the prepaid or periodic charge received by PHN is forwarded to health care providers does not remove the compensation received from the category "prepaid or periodic charge." (See Comm. Op. 77/10H.)

Our primary inquiry, therefore, is whether the obligations of PHN and the arrangements made by it to develop and maintain its health care delivery system, termed the PHN Network and consisting of various Health Care Facilities, Professional Practice Groups, and Health Care Professionals, constitutes "undertaking to arrange for the provision of health care services" within the meaning of Section 1345(f). In this connection, Section 1399.5 of the Act uses the phrase "provides, administers or otherwise arranges". That phrase does not refer to the performance of only purely ministerial functions in connection with another person's obligation to provide, arrange for the provision of, or pay for any part of the cost of, health care services, but rather refers to the activity of a person primarily or secondarily obligated to exercise discretion in securing health care services through contracts with providers or otherwise. (See Comm. Op. 79/3H.) Such an obligation is set forth in a "plan contract", which is defined in Section 1345(q) of the Act to mean a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services are furnished. As indicated in Comm. Op. 78/6H, the phrases "to arrange" and "provides, administer or otherwise arrange" are entirely consistent: the latter phrase, used in Section 1399.5, merely demonstrates the breadth of the term "to arrange" used in Section 1345(f).

Inasmuch as the Payor Participation Agreements with third-party Payors obligate PHN to develop and maintain the PHN Network which includes various Health Care Providers who have entered articipation Agreements with PHN, and to provide various administrative services in coordinating and expediting the Program, we are unable to conclude that the functions of PHN are merely ministerial. Accordingly, it appears that PHN is arranging for the provision of health care services and that under ordinary circumstances PHN would be a health care service plan within the meaning of Section 1345(f) of the Act.

However, the circumstances surrounding PHN's Network consisting of contracts among third-party Payors, PHN, Health Care Facilities, Professional Practice Groups, and Health Care Professionals suggest another conclusion. Specifically, written contracts, termed Services Agreements, directly between a Payor and one or more Health Care Facilities or Health Care Professionals selected by such Payor and to which neither PHN nor Medical Group is a party, must be in effect in order for such Health Care Provider(s) to furnish services to Beneficiaries of the Payor through the PHN Network. Each Services Agreement specifies the health care services to be provided, the amount of the fee-for-service compensation to be paid by the third-party Payor to the Health Care Provider, the circumstances for payment thereof, and other terms affecting such compensation. Services Agreements are negotiated, if at all, solely between the particular third-party Payor and the particular Health Care Provider without any involvement or assistance of PHN or Medical Group other than the ministerial act of transmitting the Payor's offers. Thus, while the arrangements of PHN (and with respect to Health Care Professionals, Medical Group) are a necessary condition for the operation of the PHN Network, a written contract between a particular third-party Payor and one or more Health Care Providers selected by such Payor is the sufficient condition for the provision of health care services through the PHN Network to Beneficiaries of the Payor so long as the arrangements of PHN (and, with respect to Health Care Professionals, Medical Group) remain in effect. It is also significant that under the arrangements undertaken by PHN and Medical Group, neither PHN nor Medical Group is to pay or forward to any participating Health Care Provider any fee-for-service or other compensation for the provision of health care services or to receive payments of any third-party Payor for such purposes. Rather, such payments are solely the obligation of the third-party Payor. Accordingly, it is our view that, although PHN undertakes to arrange for the provision of health care services to Beneficiaries, those arrangements of PHN are superceded by the arrangements necessarily made by the third-party Payor itself in order for health care services to be provided through the PHN Network to the Payor's Beneficiaries. Thus, the Participation Agreements between Payors and PHN do not constitute plan contracts within the meaning of Section 1345(g) of the Act. The circumstances in the instant case are distinguished from those in Comm. Op. 77/10H, inasmuch as the arrangements in that case were not superceded by the arrangements of bona fide third-party Payors.

In conclusion, therefore, based upon the representations contained in the letters referred to above and the materials submitted therewith, it is our opinion, assuming, as you have indicated, that PHN contracts through Participation Agreements only with bona fide third-party Payors, that PHN is not a health care service

plan within the meaning of Section 1345(f) of the Act and need not be licensed pursuant to Section 1349 of the Act. This, of course, is not to say that any contracts between PHN and any health care service plans within the meaning of Section 1345(f) and not exempted by, or pursuant to, Section 1343 would not be subject to review and approval under the Act, inasmuch as Section 1367(h) of the Act requires that all contracts of a health care service plan with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of the Act.

Assuming, as you have suggested, that neither PHN nor Medical Group will conduct any presentation or advertising on behalf of a health care service plan, where information regarding the plan, or services offered and charges therefore, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan within the meaning of Section 1345(k), it is our opinion that neither PHN nor Medical Group would be a solicitor firm within the meaning of Section 1345(m) and subject to regulation as a solicitor firm under the Act.

You have not requested our opinion, and we express no opinion, as to whether any third-party Payor executing a Participation Agreement with PHN and Services Agreements with Health Care Providers participating in the PHN Network are, by virtue of such arrangements or otherwise, health care service plans within the meaning of Section 1345(f) and subject to the licensure requirement of Section 1349 of the Act.

Dated: Sacramento, California

By order of
FRANKLIN TOM
Commissioner of Corporations

ROBERT E. LA NOUE
Assistant Commissioner
(916) 322-3553

STATE OF CALIFORNIA --BUSINESS AND TRANSPORTATION AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CORPORATIONS
1025 P STREET, Room 205
SACRAMENTO, CALIFORNIA 95814
(916) 445-7205

IN REPLY REFER TO

FILE NO OP 4730H
WLB

COMMISSIONER'S OPINION

THIS INTERPRETIVE OPINION IS ISSUED BY THE COMMISSIONER OF CORPORATIONS PURSUANT TO SECTION 1344(b) OF THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. IT IS APPLICABLE ONLY TO THE TRANSACTION IDENTIFIED IN THE REQUEST THEREFOR, AND MAY NOT BE RELIED UPON IN CONNECTION WITH ANY OTHER TRANSACTION.

James M. Mattesich
Livingston & Mattesich
Attorneys at Law
1130 K Street, Suite 250
Sacramento, California 95814

Dear Mr. Mattesich:

The request for an interpretive opinion, contained in your letter dated August 24, 1983, as supplemented by your letter dated August 30, 1983, and the materials submitted therewith, has been considered by the Commissioner. Your letter raises the question whether Affordable Health Care Concepts, Inc. ("AHCC"), is a health care service plan within the meaning of Section 1345(f) and subject to the licensure requirement of Section 1349 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").

You have represented that AHCC will assist and represent purchasers of health care services in the implementation of new programs for cost containment. AHCC's plan of business is to act as a consultant to such entities and assist them in negotiating plans which provide improved health care services at a reduced cost. The contract between AHCC and its clients provides that the client appoints AHCC as its agent for the purpose of soliciting health care providers to enter into contracts for the provision of health care services with the client based upon alternative rates of reimbursement. Under the contract with its clients, AHCC has these duties: to review the nature and extent of the current benefits under the client's health and welfare indemnity programs; to prepare, present for the client's approval, and disseminate [illegible]tations to bid from health care providers to contract with the [illegible]ent, to engage in negotiations on the client's behalf with [illegible]lth care providers to obtain contracts based on alternative [illegible] to present the negotiated contracts to the client for its

approval; and to monitor, where the client and AHCC agree it is appropriate, the negotiated contracts and to report to the client based upon a plan approved by the client. Negotiations for provider contracts by AHCC on the client's behalf shall be conducted solely for the client and shall not be carried on jointly or in concert with negotiations by AHCC for other clients of AHCC. The client shall retain in its sole discretion the right to accept or reject the terms of the contracts negotiated on its behalf by AHCC. The term of the client's contract with AHCC is one year, except that the agreement is automatically renewed for a period of an additional year if neither party gives notice of termination within 30 days preceding the expiration date.

AHCC is to receive from each client, by the tenth day of each month following the date of the agreement, a monthly fee consisting of 25 cents per family enrolled in client's health and welfare indemnity programs as of the first day of each month regardless of whether the client enters into any health care contracts negotiated by AHCC. The agreement between AHCC and a client may be terminated by either party prior to the expiration of the agreement upon thirty days written notice to the other party, provided, however, that the client would remain obligated to pay the monthly fee indicated above to AHCC for so long as any provider contract negotiated for the client by AHCC remains in effect.

You have also represented that AHCC does not have copies of the "invitations to bid" or of the contracts which it will negotiate on behalf of clients, as these documents will be drafted on an individual, client-by-client basis. AHCC will not be a party to the health care service contracts which it negotiates and will not undertake to provide health care services to beneficiaries. AHCC will not sign the contracts it negotiates for its clients nor will AHCC's trade name, logo or trademark appear on such contracts. Although AHCC has no clients under contract at this time, it expects that virtually all of its clients will be self-insured. In the limited instances where AHCC represents a client which is not self-insured, AHCC will not become the agent of the third-party payor. AHCC will not be involved in the financing or claims administration of any health care service contracts it assists its principals to negotiate. AHCC will not be responsible for billing or collection, and it will not bear any economic risk related to the delivery of health care services. AHCC will not receive, disburse or in any manner handle the monies provided by payors to health care providers. AHCC will not market health care service plans to beneficiaries.

Section 1345(f) of the Act defines "health care service plan" to include any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or

to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees. Section 1399.5 provides that the Act shall be applicable to any private or public entity or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, unless such entity is exempted from the provisions of the Act by, or pursuant to, Section 1343. Section 1349 of the Act provides that it is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the Commissioner a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder.

In the instant case AHCC is to act as consultant and agent to negotiate for its clients health care service contracts with health care providers with alternative rates of reimbursement in the interest of cost containment. While the negotiations with health care providers to be conducted by AHCC will result in contracts for the provision of health care services to the enrolled families of AHCC's clients, AHCC will neither sign or be a party to such contracts, nor will its trade name, logo or trademark appear on such contracts. Those contracts are subject to the approval of the client, and, we assume, will not become effective unless and until they are signed by the client. Also subject to the client's approval will be the 'invitations to bid", which we assume that AHCC will disseminate prior to engaging in negotiations. Finally, if AHCC and the client agree that it is appropriate, AHCC will monitor the negotiated contracts and report to the client based upon a plan approved by the client.

Inasmuch as the payments to be paid by clients to AHCC are monthly payments calculated with reference to the number of families enrolled in the client's "health and welfare indemnity programs", it is our opinion that such payments constitute prepaid or periodic charges paid to AHCC by or on behalf of subscribers or enrollees within the meaning of Section 1345(f) of the Act. (See OP 4064H and Comm. Op. 77/10H.)

Therefore, as in OP 4664H, our primary inquiry is whether the obligations of AHCC and the arrangements made by it to develop and, in some cases, to monitor, the health care delivery system for its client, constitute "undertaking to arrange for the provision of health care services" within the meaning of Section 1345(f) of the Law. In this connection, Section 1399.5 of the Act [illegible] the phrase "provides, administers or otherwise arranges". [illegible] phrase does not refer to the performance of only purely

ministerial functions in connection with another person's obligation to provide, arrange for the provision of, or pay for any part of the cost of, health care services, but rather refers to the activity of a person primarily or secondarily obligated to exercise discretion in securing health care services through contracts with providers or otherwise. (See Comm. Op. 79/3H.) Such an obligation is set forth in a "plan contract", which is defined in Section 1345(q) of the Act to mean a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services are furnished. As indicated in Comm. Op. 78/6H, the phrases "to arrange" and "provides, administer or otherwise arrange" are entirely consistent: the latter phrase, used in Section 1399.5, merely demonstrates the breadth of the term "to arrange" used in Section 1345(f).

Inasmuch as AHCC negotiates the terms and provisions of contracts providing for the provision of health care services to the enrolled families of AHCC's client, and monitors some such contracts, we are unable to conclude that the functions of AHCC are merely ministerial. However, since each contract for the provision of health care services which results from the negotiations of AHCC is subject to the approval of AHCC's client, and, we assume, is ineffective unless and until signed by the client, and no such contract contains the trade name, logo, or trademark of AHCC, it appears that any arrangements made by AHCC are only a necessary condition for the benefits to be provided to beneficiaries of AHCC's client, and that the approval and signature of the client on the contract is the sufficient condition for the provision of services to the client's enrolled families pursuant to the contract between the client and the health care providers. We also understand that AHCC is not to pay or forward to any health care provider any fee-for-service or other compensation for the provision of health care services or to receive payments of any client for such purposes. Based upon these considerations, therefore, it is our view that although AHCC undertakes to negotiate arrangements for the provision of health care services to the enrolled families of AHCC's clients, any arrangements of AHCC are preliminary and are superseded by the arrangements necessarily made by AHCC's client in order for the contract between AHCC's client and the health care provider to become effective and for the health care services to be provided to the enrolled families of the client.

In conclusion, therefore, based upon the representations contained in your letters and the materials submitted therewith, and the assumptions noted above, it our opinion that AHCC is not a health care service plan within the meaning of Section 1345(f) of the Act and need not be licensed pursuant to Section 1349 of the Act.

This, of course, is not to say that any contracts between AHCC and any health care service plans within the meaning of Section 1345(f) and not exempted by, or pursuant to, Section 1343 would not be subject to review and approval under the Act, inasmuch as Section 1367(h) of the Act requires that all contracts of a health care service plan with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of the Act.

Assuming, as you have suggested, that AHCC will not conduct any presentation or advertising on behalf of a health care service plan, where information regarding the plan, or services offered and charges therefore, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan within the meaning of Section 1345(k), it is our opinion that AHCC would not be a solicitor firm within the meaning of Section 1345(m) or subject to regulation as a solicitor firm under the Act.

You have not requested our opinion, and we express no opinion, as to whether any third-party payor or other client executing a contract with AHCC is, by virtue of such contract, or the contracts negotiated by AHCC or otherwise, a health care service plan within the meaning of Section 1345(f) and subject to the licensure requirement of Section 1349 of the Act. You have also not requested our opinion, and we express no opinion as to whether any health care provider contracting with a client of AHCC pursuant to a contract negotiated by AHCC is, by virtue of such contract or otherwise, a health care service plan within the meaning of Section 1345(f) and subject to the licensure requirement of Section 1349 of the Act.

Dated: September 19, 1983
Sacramento, California

By order of
FRANKLIN TOM
Commissioner of Corporations

ROBERT E. LA NOUE
Assistant Commissioner
(916) 322-3553

SUBCHAPTER 5.5. HEALTH CARE SERVICE PLANS

(Originally printed 6-5-76)

DETAILED ANALYSIS

Article 7. Standards

Article 8. Self-Policing Procedures

Article 9. Financial Responsibility

Article 10. Medical Surveys

Article 11. Examinations

Article 12. Reports

1300.43.3. Rural Ambulance Plans.

(a) A health care service plan which provides pursuant to a plan contract only ambulance services to subscribers and enrollees located in one or more rural service area is exempted from all provisions of the Act except those provisions hereinafter specified, subject to the condition that such plan give written notice to the Commissioner of its intention to rely upon this exemption, signed by an officer or partner of the plan or its sole proprietor, as the case may be, such notice to be in the following form and contain the following information:

DEPARTMENT OF CORPORATIONS
State of California

NOTICE OF INTENTION TO RELY UPON THE RURAL AMBULANCE PLAN EXEMPTION UNDER THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

Date _____, 19____

The Plan named below hereby files notice with the Commissioner of Corporations of its intention to rely upon the rural ambulance plan exemption set forth in Section 1300.43.3, Title 10, California Administrative Code, and makes the following statements in connection therewith:

1. Name of Plan

_____

Mailing address of Plan

_____

Number and Street or P.O. Box City State Zip

_____

Fictitious name used in business (if none, so state)

_____

2. Form of organization of Plan

_____

(State whether the Plan is a corporation, partnership, sole proprietorship or other form of organization and, if "other", explain in an attachment.)

The name of each person owning 10% or more of the ownership interests in the Plan is:

_____ _____

_____ _____

_____ _____

3. The Plan serves only the rural service area or areas (as defined in Subsection (c) of Section 1300.43.3, Title 10, California Administrative Code) which is (are) identified on the attached map. No such area contains any part of any city or town which has a population of 25,000 or more persons.

(Attach a map which clearly delineates the area(s) served by the Plan.)

Article 13. Books and Reports

Article 14. Miscellaneous Provisions

Article 15. Charitable or Public Activities

1300.43. Small Plans.

A health care service plan or specialized health care service plan which provides health care services or specialized health care services only to the employees of one employer, or only to the employees of employers under common ownership and control, which is administered solely by the employer, and which does not have more than five subscribers (regardless of the number of persons enrolled based upon their relationship to or dependence upon such subscribers) is exempt from all provisions of the Act and the rules thereunder, except Sections 1381, 1384 and 1385. Such plans are exempt from any rules adopted pursuant to such sections unless such rules are made specifically applicable to plans exempted under this section.

NOTE: Authority cited: Section 6, Chapter 941, Statutes 1975, and Section 1344, Health and Safety Code. Reference: Knox-Keene Health Care Service Plan Act of 1975.

HISTORY:

1. New Subchapter 5.5, Articles 1–14 (§§ 1300.43–1300.99, not consecutive) filed 6-1-76; effective thirtieth day thereafter (Register 76, No. 23).

1300.43.1. New Plans.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. Amendment filed 11-30-76 as an emergency; effective upon filing (Register 76, No. 49). For prior history, see Register 76, No. 42.
2. Reinstatement of section as it existed prior to emergency amendment filed 11-30-76, by operation of Section 11422.1(b), Government Code (Register 77, No. 24).
3. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

1300.43.2. Extension for Enrollers Under Medi-Cal Program.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 8-12-76 as an emergency; effective upon filing (Register 76, No. 33).
2. Amendment filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).
3. Amendment filed 10-12-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 42).
4. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

4. The number of subscribers, enrollees and family units served by the Plan is as follows:

Number of subscribers _____
Number of enrollees _____
Number of family units _____

(See Subsections (c) and (o) of Section 1345 of the Knox-Keene Health Care Service Plan Act of 1975 for the definitions of "subscriber" and "enrollee".)

5. The books and records of the Plan are maintained at the following location:

_____

Number and Street City State Zip

The name of the person having custody of such books and records is:

_____

6. Attached is a brief description of the Plan, setting forth the following items of information:

a. The street address of each of the Plan's business locations, and a description of the functions of each such facility.

b. The number of ambulances owned or operated by the Plan and their customary locations.

c. A brief description of the Plan's history, including the date it initially contracted with subscribers pursuant to a plan contract, whether it offers different types of plan contracts, and the source of its subscriptions (i.e., group contracts, individual subscriptions, advertising, other solicitation).

d. Any significant changes in the Plan which are anticipated during the next 12 months.

7. The Plan hereby gives the following undertakings to the Commissioner of Corporations:

a. That it has a currently effective license pursuant to Articles 1 and 2 of Chapter 2.5 of Division 2 of the California Vehicle Code, and that it will maintain such license in good standing while operating pursuant to the rural ambulance plan exemption.

b. That the Plan will not receive prepaid or periodic charges pursuant to its plan contract for more than one year in advance.

c. That it will file an amendment to this notice within 30 days of any material change in the information provided pursuant to items 1, 2, 3, or 5.

d. That it will give written notice to the Commissioner of Corporations within 15 days in the event it terminates its operations as a health care service plan.

e. That it will comply with Sections 1360, 1365(a), 1373, 1379, 1381, and 1385, and with Subsections (a), (d) and (f) of Section 1384 of the Knox-Keene Health Care Service Plan Act of 1975.

f. That it will deliver to each subscriber a copy of its plan contract, and that such contract will prominently display the following legend:

"(Name of Plan) is a health care service plan operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975. Complaints regarding this contract and the services furnished thereunder may be directed to the Commissioner of Corporations of the State of California."

g. That, if any disclosure form or evidence of coverage is used by the Plan, each such disclosure form and/or evidence of coverage will comply with Sections 1362 and 1363 of the Knox-Keene Health Care Service Plan Act of 1975 and the rules of the Commissioner of Corporations pursuant thereto.

8. The Plan has caused this Notice to be signed on its behalf by the undersigned, thereunto duly authorized.

Name of Plan _____
By _____
Title _____

The following verification is to be executed by the person signing the Notice on behalf of the Plan:

I certify under penalty of perjury that I have read this Notice and the attachments thereto and know the contents thereof, and that the statements therein are true and correct.

Executed at _____ on _____, 19____
(City and State)

_____
Signature of Declarant

(If executed in a jurisdiction which does not permit verifications under penalty of perjury, attach a verification executed and sworn to before a notary public.)

(b) A plan's exemption pursuant to this rule may be terminated by order of the Commissioner, upon a determination that such action is in the public interest and for the protection of subscribers and enrollees, for any of the following reasons:

(1) The plan is operating at variance with the documents and information contained in its current notice filed pursuant to Subsection (a).

(2) The services of the plan are not reasonably accessible to subscribers and enrollees.

(3) The plan, or a person employed by the plan, has failed to comply with licensing or certification requirements imposed by law.

(4) The plan is operating in a manner which is unfair, unreasonable or discriminatory as to its subscribers and enrollees or as to its enrollment practices.

(5) The financial condition of the plan is such that its continued operation will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has engaged in conduct proscribed by Subparagraphs (6), (7), (8), (9), (10) or (11) of Section 1386(b) of the Act.

(7) The plan has violated any condition of this exemption; provided that nothing contained herein shall be construed to permit reliance upon this exemption notwithstanding noncompliance with all its provisions.

(c) For the purposes of this section, "rural service area" means a geographic area which is predominantly rural and which contains no part of any city or town (as "city" and "town" are defined by Sections 20 and 21 of the Government Code) the population of which is 25,000 or more.

(d) For the purposes of this section, "ambulance services" means the emergency and nonemergency transportation by a person licensed pursuant to Articles 1 and 2 of Chapter 2.5 of Division 2 of the Vehicle Code of persons who are ill, injured, or wounded, and such health care services as are provided for the duration of such transportation.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).
2. Certificate of Compliance filed 1-27-77 (Register 77, No. 5).
3. Amendment filed 4-2-79; effective thirtieth day thereafter (Register 79, No. 14).
4. Editorial correction of subsections (a)7.f. and (b)(6) (Register 80, No. 4).

1300.43.4. Employee Welfare Benefit Plans.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. Amendment filed 3-6-78 as an emergency; designated effective 3-6-78 (Register 78, No. 10). For prior history, see Register 77, No. 36.
2. Certificate of compliance filed 4-20-78 (Register 78, No. 16).
3. Amendment filed 8-14-78 as an emergency; designated effective 8-15-78 (Register 78, No. 33).
4. Certificate of Compliance filed 11-8-78 (Register 78, No. 45).
5. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

1300.43.5. Exemption for Licensees of Insurance Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Certificate of Compliance filed 4-4-78 (Register 78, No. 14).
3. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.43.6. Moribund Plans.

A health care service plan which is a general acute care hospital whose business as a plan is limited to providing, administering, or otherwise arranging for the provision of health care services to members of one moribund group of not more than 250 members is exempted from the provisions of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is licensed as a health facility pursuant to Chapter 2 (commencing with Section 1250) of the Health and Safety Code, and is not insolvent.

(b) That such plan has not accepted any new members for the last twenty years and does not accept any new members for the duration of this exemption.

(c) That such plan receives prepaid or periodic charges, if any, from members of such group in an amount not exceeding $5 per member per month and has received no substantial payment or transfer of property from or on behalf of such contracting group during the last twenty years.

(d) That such plan derives not more than one-half of one percent of its annual income from prepaid or periodic charges paid by or on behalf of members of such group, and has a minimum net worth of $15,000,000 based upon its most recent certified financial statements (prepared as of a date within the preceding 15 months).

(e) That such plan establish and maintain a grievance procedure substantially complying with Section 1300.68.

(f) That such plan deliver to each subscriber and enrollee within 60 days of the adoption of this section, and thereafter to any subscriber or enrollee upon request, the following written notice:

"(Name of plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975 PROVIDED BY RULE OF THE COMMISSIONER OF CORPORATIONS OF THE STATE OF CALIFORNIA."

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 6-13-78 as an emergency; effective upon filing (Register 78, No. 24).
2. Certificate of Compliance filed 8-18-78 (Register 78, No. 33).

1300.43.7. Student Emergency Care Arrangements.

There is exempted from the provisions of the Act any nonprofit corporation or association all of whose members are licensed physicians and which is a health care service plan as defined by subdivision (f) of Section 1345 only by reason of health care service plan contracts with one or more colleges or universities pursuant to which such nonprofit corporation or association furnishes or arranges only emergency health care services and health care services ancillary thereto to members of the student body of, employees of, and visitors to such colleges or universities, provided that each of the following conditions is met:

(a) At least 95 percent of the cost of health care services furnished pursuant to such contracts is furnished by employees or members of such nonprofit corporation or association or contracting providers.

(b) All services furnished by members pursuant to such contracts are furnished pursuant to provider contracts which comply with Section 1379 of the Act.

NOTE: Authority cited: Section 1343, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 8-22-78; effective thirtieth day thereafter (Register 78, No. 34).

1300.43.8. Public Agencies.

NOTE: Authority cited: Section 1343, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.43.9. Unlicensed Solicitors and Solicitor Firms.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 11-9-79 as an emergency; effective upon filing (Register 79, No. 45). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-9-80.
2. Repealed by operation of Section 11422.1(c), Government Code (Register 80, No. 24).

1300.43.10. Nonprofit Retirees' Plan.

A health care service plan which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976, whose activity as a plan is limited to reimbursing part or all of the cost of health care services as a supplement to Medicare (Parts A and B) to persons who were retired from professions associated with higher learning after having been employed therein for not less than 10 cumulative years and such persons' spouses, providing all such persons are enrolled in Medicare, is exempted from the provisions of Section 1349 of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is a nonprofit corporation which does not engage, directly or indirectly, in any for profit business, which is not affiliated with (Rule 1300.45(c)) a corporation or other entity which engages, directly or indirectly, in any for profit business, and which does not contract or otherwise arrange for the performance by persons other than its directors, officers or employees of any portion of its administrative or other functions.

(b) That such plan is exempted from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code and from state income tax on similar grounds.

(c) That such plan is a charitable corporation subject to, and in compliance with, the Uniform Supervision of Trustees for Charitable Purposes Act.

(d) That such plan does not directly provide any health care services through entity-owned or contracting health facilities or providers.

(e) That such plan has a tangible net equity within the meaning of Section 1300.76(b) of not less than $300,000, including liquid tangible assets in an amount not less than $300,000, based upon its most recent certified financial statement (prepared as of a date within the preceding 15 months and such other date as may be requested by the Commissioner pursuant to Section 1384 of the Act) and its most recent quarterly and monthly uncertified statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $1,000 for each person enrolled in excess of 400; provided that the maximum number of enrollees shall not exceed 500.

(f) That not more than 15% of the total charges paid by or on behalf of subscribers or enrollees for enrollment in, or for health care benefits from, such plan is expended for administrative costs, including all costs of solicitation and enrollment; except that such plan may expend additional sums of money for administrative costs excluding costs of solicitation and enrollment provided that such money is not derived from revenue obtained from subscribers or enrollees.

(g) That such plan issues a uniform health care service plan contract to all subscribers

(1) which provides, except for a permissible calendar year deductible not to exceed $100 per enrollee, full coverage for all copayments and deductibles relating to allowable charges under Medicare (Parts A and B) for all health care services covered by Medicare (Parts A and B) pursuant to Title XVIII of the Social Security Act as amended, and not less than 50% of the reasonable charges for each health care service which is not covered by Medicare but is covered by such plan; provided, however, that such coverage may be subject to a lifetime limitation allowing not less than $300,000 of benefits per lifetime and

(2) which provides that an enrollment or subscription may not be cancelled except upon grounds complying with Section 1365 of the Act.

(h) That such plan provides to each subscriber a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act and which also states, if such is the case, that such contract does not cover, and that subscribers and enrollees will be solely liable for,

(1) any charges in excess of allowable charges under Medicare with respect to health care services covered by Medicare,

(2) any charges in excess of reasonable charges for any health care services covered by such plan but not covered by Medicare and any copayments related to such health care services, and

(3) any permissible plan deductible.

(i) That no less than 75% of the officers and of the directors of such corporation are persons who are retired from the professions associated with higher learning after having been employed therein not less than 10 cumulative years, are enrolled in Medicare, and are enrolled in such plan subject to terms and conditions no more favorable than any other enrollee, and that no officer or director receives any compensation from such corporation.

(j) That such plan solicits enrollments or subscriptions in this state only through persons who are officers or employees of such plan.

(k) That such plan establishes and maintains a grievance procedure substantially complying with Section 1300.68 of these rules.

(l) That such plan not represent any contract of such plan as a Medicare supplement contract and discloses to each prospective subscriber and enrollee when presenting any information regarding the plan, and again at the time of application, the following written notice:

"THE HEALTH PLAN CONTRACT OFFERED BY (Name of plan) DOES NOT MEET THE REQUIREMENTS FOR CERTIFICATION AS A MEDICARE SUPPLEMENT CONTRACT PURSUANT TO APPLICABLE STATE OR FEDERAL LAW, AND HAS NOT BEEN CERTIFIED. PERSONS DESIRING INFORMATION REGARDING CERTIFIED MEDICARE SUPPLEMENT COVERAGE SHOULD CONTACT THEIR LOCAL MEDICARE OFFICE."

(m) That such plan delivers to each subscriber and enrollee within 60 days of the adoption of this section, and annually thereafter, the following written notice:

"(Name of plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE COMMISSIONER OF CORPORATIONS OF THE STATE OF CALIFORNIA."

(n) That such plan provides written notice to the Commissioner of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d) and (g) of this section.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).
2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.43.11. Exemption for Solicitors of Nonprofit Retirees' Plans.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.43.12. Medi-Cal Dental Contract.

The contract of the Department of Health Services which is entered as the result of successful bidding in response to said Department's request for proposal and which requires the contractor to provide only dental benefits for the state's Medi-Cal beneficiaries pursuant to Section 14104.3 of the Welfare and Institutions Code and incorporates the terms and provisions set forth in the request for proposal, is exempt from the provisions of the Act, if the successful bidder ("entity") is not already licensed under the Act, for the period indicated below, subject to each of the following:

(a) The entity engages in no activities as a plan other than those pursuant to the Medi-Cal dental contract described above or pursuant to a separate exemption in the Act or these rules.

(b) The entity properly files an application for licensure under the Act, as required by Sections 1351 and 1356 of the Act, prior to executing the contract referred to above, except that the information contained in the application submitted at the time of filing need not include information not required to be provided to the Department of Health Services pursuant to its request for proposal, so long as the additional information required by Section 1351 of the Act or by the application form provided by the Commissioner is filed as an amendment to the license application within six weeks of the date of execution of the contract referred to above, or any longer period as the Commissioner by order may allow under the Commissioner's waiver authority set forth in Section 1344(a) of the Act.

(c) The entity reasonably pursues the completion of its application and compliance with the provisions of the Act and applicable rules thereunder.

(d) The entity, for the duration of the exemption provided by this section, shall be subject to the provisions of Sections 1351.1, 1381, 1384, and 1385 of the Act, and may be examined by the Commissioner in the manner and subject to the arrangements provided in Section 1382 of the Act.

(e) The exemption provided by this section shall be effective only until the earlier of (1) final action by the Commissioner on the application, or (2) the expiration of nine months after execution of the contract referred to above, except that said nine month period may be waived by order of the Commissioner for any additional one month periods under the Commissioner's waiver authority set forth in Section 1344(a) of the Act.

(f) For the purposes of this section, the term "order" means a written waiver applicable to a specific case issued by the Commissioner pursuant to Section 1344(a) of the Act.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343, 1344, 1351, 1351.1, 1353, 1356, 1381, 1382, 1384 and 1385, Health and Safety Code

HISTORY:

1. New section filed 3-9-84, effective thirtieth day thereafter (Register 84, No. 10).

1300.43.13. Mutual Benefit Plans.

A health care service plan which is a bona fide mutual benefit society within the meaning of this section and which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976 is exempted from the provisions of the Knox-Keene Health Care Service Plan Act, except as otherwise indicated below, subject to each of the following conditions:

(a) That such a plan is a corporation organized and operating as a California nonprofit corporation; does not engage, directly or indirectly, in any for-profit business; is not affiliated (Rule 1300.45(c)) with any other plan or with any corporation or other entity which engages, directly or indirectly, in any for-profit business; and does not contract or otherwise arrange for the performance of any portion of its administrative functions by persons other than its officers, directors, or employees.

(b) That such plan consists of a mother lodge and not more than one subordinate lodge; provided, however, that such mother lodge and any such subordinate lodge are located in a county whose population exceeds 1,500,000 persons.

(c) That the assets and funds available for the payment of health care services are held in trust by and under the sole control of the mother lodge exclusively for the benefit of the beneficiary members of the mother lodge and any subordinate lodge.

(d) That such plan is exempted from federal income tax as an organization described in Section 501(c)(8) of the Internal Revenue Code and from state income tax on similar grounds.

(e) That such plan is in compliance with the Uniform Supervision of Trustees for Charitable Purposes Act (Article 7 (commencing with Section 12580) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code.)

(f) That such plan not practice any discrimination in violation of state or federal law or constitutional provision.

(g) That the beneficial membership in such plan is limited to beneficial members of the mutual benefit society (including only the mother lodge and any subordinate lodge) and consists of a total of not more than 800 persons.

(h) That such plan not receive any prepaid or periodic charges, except that admission fees of not more than $500 per each beneficial or social member may be received and dues of not more than $100 per each beneficial or social member per year may be received, provided, however, that no part of any admission fees or membership dues may be deposited in the health care trust or used to pay for or reimburse any part of the cost of health care services.

(i) That such plan, at all times while it relies upon this exemption, has a tangible net equity within the meaning of Section 1300.76(b) of not less than $500,000, including liquid tangible assets in an amount not less than $500,000, based upon its most recent annual certified financial statement and its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $1,000 for each beneficial member in excess of 700; provided that the maximum number of beneficial members shall not exceed 800.

(j) That such plan, upon request of the Commissioner, pursuant to Section 1384(a) of the Act, submits to the Commissioner a copy of its most recent annual certified financial statement, and, upon request of the Commissioner pursuant to Section 1384(f) of the Act, submits to the Commissioner its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement.

(k) That such plan issues to all beneficial members health care service plan contracts which provide at least all of the benefits indicated below, except that such contracts may diminish or qualify any of the benefits indicated below through the use of such copayments, limitations, and other terms as may be determined from time to time by vote of the plan's beneficial members:

(1) Physician services (including consultation and referral) through contracting physicians;

(2) Hospital inpatient services through at least one contracting nonprofit, nongovernmental hospital;

(3) Hospital outpatient services through at least one contracting nonprofit, nongovernmental hospital when prescribed by the treating, contracting physician.

(*l*) That all of the plan's contracts with providers comply with, and recite that the contracting providers are bound by, the provisions of Section 1379 of the Act.

(m) That such plan provides to each beneficial member a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act.

(n) That the officers and directors of such corporation are enrolled in such plan subject to terms and conditions no more favorable than any other beneficial member, and that no officer or director receives any compensation from such corporation.

(o) That such plan solicits beneficial members in this state only through persons who are officers, directors, or employees of such plan, and not by means of any unsolicited telephone call or written or printed communication or by radio, television, or similar communications media.

(p) That such plan establishes and maintains a grievance procedure substantially complying with Section 1368 of the Act.

(q) That such plan delivers to each beneficial member within 60 days of the effective date of this section, and annually thereafter, the following written notice:

"(Name of Plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE COMMISSIONER OF CORPORATIONS OF THE STATE OF CALIFORNIA."

(r) That such plan provides, within 60 days of its initial reliance on this section, and within 30 days of any subsequent request of the Commissioner therefor, written notice to the Commissioner of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d), (e), (f), (g), (h), (i), (k), (l), and (m) of this section.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343 and 1344, Health and Safety Code.

HISTORY:

1. New section filed 6-5-84; effective thirtieth day thereafter (Register 84, No. 23).

Article 2. Administration

1300.44. Interpretive Opinions.

NOTE: Authority cited: Section 1344, Health and Safety Code.

HISTORY:

1. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

1300.44.1. Application for Exemption From Rule.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344, 1351 and 1352, Health and Safety Code.

HISTORY:

1. Amendment of subsection (b) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

1300.45. Definitions.

In addition to the definitions contained in Section 1345 of the Act, the following definitions apply to the interpretation of these rules and the Act:

(a) "Act" means the Knox-Keene Health Care Service Plan Act of 1975.

(b) "Advertisement" includes the disclosure form required pursuant to Section 1363 of the Act.

(c) Except in connection with Sections 1351.1 and 1352 of the Act, "an affiliate" of a person is a person controlled by, under common control with, or controlling such person.

(d) The term "control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting shares, debt, by contract, or otherwise.

(e) The term "certified" or "audited", when used in regard to financial statements, means examined and reported upon with an opinion expressed by an independent public or certified public accountant.

(f) "Code" means the California Health and Safety Code.

(g) "Copayment" means an additional fee charged to a subscriber or enrollee which is approved by the Commissioner, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(h) "Department" means the California Department of Corporations.

(i) "Facility" means

(1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of a plan or any affiliate thereof, and

(2) any premises maintained by a provider to provide services on behalf of a plan.

(j) "Family unit" means a unit composed of a subscriber and each person whose eligibility for benefits is based upon such person's relationship with, or dependency upon, such subscriber.

(k) "Hospital based plan" means a health care service plan which owns, operates or is affiliated with a hospital as an integral part of delivering health care services.

(*l*) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(m) "Primary care physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

(n) "Principal creditor" means (1) a person who has loaned funds to another for the operation of such other person's business, and (2) a person who has, directly or indirectly, 20 percent or more of the outstanding debts of a person.

(o) "Principal officer" means a president, vice-president, secretary, treasurer or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

(p) "Surcharge" means an additional fee which is charged to a subscriber or enrollee for a covered service but which is not approved by the Commissioner, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(q) The term "generally accepted accounting principles", when used in regard to financial statements, assets, liabilities and other accounting items, means generally accepted accounting principles as used by business enterprises organized for profit. Accordingly, Financial Accounting Standards Board statements, Accounting Principles Board opinions, accounting research bulletins and other authoritative pronouncements of the accounting profession should be applied in determining generally accepted accounting principles unless such statements, opinions, bulletins and pronouncements are inapplicable. Section 510.05 of the AICPA Professional Standards, in and of itself, shall not be sufficient reason for determining inapplicability of statements, opinions, bulletins and pronouncements.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344 and 1345, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. New subsection (q) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
3. Amendment of subsection (e) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.46. Prohibition of Bonuses or Gratuities in Solicitations.

No person subject to the provisions of the Act shall offer or otherwise distribute any bonus or gratuity to potential subscribers for the purpose of inducing enrollment or to existing subscribers for the purpose of inducing the continuation of enrollment.

1300.47. Health Care Service Plan Advisory Committee.

Each member of the Health Care Service Plan Advisory Committee shall file with the Commissioner a statement setting forth the following:

(a) The firm with which such member is employed or affiliated and the capacity in which employed or affiliated.

(b) Whether such firm is a health care service plan or solicitor firm under the Act or is a provider, or a fiscal intermediary for a plan, or furnishing services, goods or facilities to any plan, solicitor firm or provider.

(c) Whether such member has any financial interest in any firm specified in (b) or receives compensation from such firm.

(d) The name of each plan in which the member is enrolled, or has been enrolled during the preceding 10 years.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1347, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

Article 3. Plan Applications and Amendments

1300.50. Notice of Intention to Apply for Plan License.

NOTE: Authority cited: Section 1344, Health and Safety Code.

HISTORY:

1. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

1300.51. Application for License as a Health Care Service Plan or Specialized Health Care Service Plan.

An application for license as a health care service plan or specialized health care service plan shall be filed upon the following form:

GENERAL INSTRUCTIONS

1. The application must be typewritten in the English language, using black ribbon.

2. Each item of the form must be completed. If inapplicable type "N/A" in the right-hand margin opposite such item.

3. Each exhibit shall be numbered by the item number (and letter, if applicable) under which it is furnished. If several exhibits are required under the same number-letter designation, they shall be given, in addition, a sequential number as indicated in the following example.

Example: In responding to Item 15A calling for copies of the plan contracts used by the applicant, an applicant employing three different contracts would label them as exhibits as follows: Exhibit 15A-1, Exhibit 15A-2, Exhibit 15A-3.

4. Except when originals are required, mechanical reproductions may be submitted. Each portion of the application and exhibits must be clearly legible.

5. When the space provided in the application form for the answer of a question is insufficient, the information must be provided in the form of an exhibit to the application numbered as specified in paragraph 3 above, and arranged in the same manner as indicated in the form.

6. Any reference herein to a rule or regulation of the Commissioner is to the rules of the Commissioner of Corporations as set forth in Title 10, California Administrative Code.

AMENDMENTS TO APPLICATION

1. An amendment to application before the issuance of a license must comply with Rule 1300.52 (see instruction 2 below). Rules 1300.52.1 and 1300.52.2 are not applicable until after an applicant has been licensed.

2. All amendments to application, before or after licensing, must comply with the following:

a. The amendment must be accompanied by a copy of the Execution Page of the application, and all portions of that page must be completed.

b. There should be attached to the Execution Page only those pages of the application or those exhibits which are changed by the amendment.

c. If a page of the application is amended, all items on that page must be completed and the changed item must be "redlined" or otherwise clearly designated.

d. If an exhibit, other than a list required by Items 13A, 13C or 24D is being amended, the applicant shall either:

(1) Furnish the complete exhibit as amended, bearing the same number as the original exhibit, with the changed portions of the exhibit "redlined" or otherwise clearly designated, or

(2) Furnish the pages of the exhibit which are amended, each page to be marked with the exhibit number and the page number of the exhibit, and with the changed portions "redlined" or otherwise clearly designated. If this method of amendment is employed, the applicant shall refile the entire exhibit as amended whenever more than 10% of its pages have been amended or promptly upon the request of the Commissioner.

e. A list furnished pursuant to Items 13A, 13C or 24D need be amended only when 10 percent or more of the names contained in the list, or in the list for a service area, have been changed. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added item "redlined" and the names of persons deleted from the list shown at the end under the heading "deletions".

OFFICIAL USE ONLY
FEE PAID $_____
RECEIPT NO. _____

Date of Application:

_____

DEPARTMENT OF CORPORATIONS
FILE NO. _____
(Insert file number of previous filings before the Department, if any.)
FILING FEE: _____
(To be completed by Applicant.) Not refundable except pursuant to Section 250.15, Title 10, California Administrative Code.

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

Note: Indicate type of filing by checking the appropriate box below:

☐ ORIGINAL APPLICATION FOR PLAN LICENSE
☐ AMENDMENT TO APPLICATION FOR PLAN LICENSE

1. Name of Applicant.
   A. Legal name: _____
   B. Fictitious names used, if any: _____
   _____

2. Applicant's Principal Executive Office.
   A. Street Address: _____
   _____
   B. Mailing Address: _____
   _____
   C. Telephone Number: ( ) _____

(Next page is 1293)

3. Person who is to receive communications regarding this application.
   A. Name: _____
   B. Title: _____
   C. Address: _____
   D. Telephone Number: ( ) _____

IMPORTANT NOTE: Applicant is required to file an amendment to this application (1) prior to a major modification of its plan or operations (Rule 1300.52.1) and (2) within 30 days after any change in the information contained in this application, other than financial information (Rule 1300.52).

4. EXECUTION: The applicant has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

_____ By _____
(Applicant) Title: _____

I certify under penalty of perjury that I have read this application and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true

Executed at _____ on _____ 19____

_____
Signature of Declarant

If executed outside California, attach a verification sworn to before a notary public.

5. Name and address of officer or partner of applicant who is to receive compliance and informational communications from the Department and who is responsible for disseminating the same within the applicant's organization:
   A. Name: _____
   B. Title: _____
   C. Address: _____
   D. Telephone Number: ( ) _____

6. Form of Organization: State applicant's form of organization ("Corporation," "partnership," "sole proprietorship" or other appropriate description.)
   A. _____
   B. Is applicant a public agency? ( ) Yes ( ) No

7. Information on Organization: (In responding to this item use the appropriate exhibit form provided as part of the application.)
   A. If applicant is a corporation, attach Exhibit 7-A ( )
   B. If applicant is a partnership, attach Exhibit 7-B ( )
   C. If applicant is a sole proprietorship, attach Exhibit 7-C ( )
   D. If applicant's form of organization is other than a corporation, partnership or sole proprietorship, attach Exhibit 7-D ( )
   E. As to each natural person named in an exhibit pursuant to Item 7, attach an Individual Information Sheet (Form HP 1300.51.1). ( )

8. Principal Creditors.
   List each creditor (1) who has loaned funds to the applicant for the operation of its business or (2) who holds, directly or indirectly, 20% or more of the obligations of the applicant. For the purposes of this item, a creditor is considered to have loaned funds to the applicant for the operation of its business if (1) the creditor has any control over the operations of the applicant, directly or indirectly, or (2) the obligation is not secured and is not by its terms payable within 12 months.

Name	Address	Amount	Terms	Relationship to Applicant

If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

9. Does any person not named in Items 7 or 8 (or any exhibit thereto) have any power, directly or indirectly, to control applicant? ( ) Yes ( ) No
If "yes" explain fully.

10. Has the applicant, its management company, or any other affiliate of the applicant, or any controlling person, officer, director, or other person occupying a principal management position in such applicant, management company or affiliate ever been convicted of a misdemeanor involving moral turpitude or of a felony? (A plea or verdict of guilty or a conviction following a plea of *nolo contendere* is a conviction for the purposes of this item.) ( ) Yes ( ) No
If "yes," identify such person and explain fully. Such explanation should be included in the personal information sheet for such person, if required by Item 11.

11. For each person named in Item 8 or 9, or in any exhibit thereunder, furnish an exhibit containing the following information:
   A. Name
   B. Business address
   C. Nature of business
   D. Type of organization (corporation, partnership, sole proprietorship, individual, etc.)
   E. If other than an individual, the names of such person's officers, directors, general partners or persons occupying similar positions or performing similar functions.
   F. If a corporation which has 300 or more shareholders, the name of each person holding of record 5% or more of such corporation's equity securities.
   G. If other than a corporation which has 300 or more shareholders, an individual or a sole proprietorship, the name of each person owning, directly or indirectly, 5% or more of such person's equity securities.

If any item on this page is amended, you must answer in full all other items on this page and file it with a completed and signed Execution Page. No exhibit required by any item on this page need be filed with an amended item unless the exhibit itself is amended.

12. Description of Plan
   A. State the service areas to be served by the applicant:

   B. Attach as Exhibit 12-B a description of applicant's plan of operation, its method of providing for health care services, its physical facilities and, if applicable, its health care delivery capabilities, and the arrangements and methods by which health care services will be provided. If the applicant serves more than one service area, cover each service area separately and, for each service area, state the following information:

( )

1. The number of hospital beds contracted for, their locations and types of licenses.
2. The number of full-time and the number of part-time primary care physicians (as defined in Rule 1300.45(m).
3. The specialties of, and the number of full-time and the number of part-time, non-primary care physicians in each specialty.
4. The major facilities of the Plan and of providers for the rendition of health services, and the health services provided at each such facility. For the purposes of this item, a "major facility" is any facility which provides, within the service area, 10 percent or more of the Plan's health services.
5. The approximate maximum number of enrollees and subscribers which can be effectively served by applicant's facilities, and the approximate maximum number which applicant intends to enroll. State the assumptions upon which these estimates are based.

13. Contracts with Providers and Others.

Instructions: (1) There may be omitted from the information required pursuant to this item contracts which are not material.

(2) If standard form contracts are used, only a specimen of such contract should be filed, together with a schedule showing as to each person with whom such standard form contract is entered into, the date of such contract and any material terms which vary in such contract from the standard form.

(3) Contracts of employment should not be filed pursuant to this item.

A. Attach for each service area of the applicant, a list of all contracts currently in effect between applicant and providers of health care services. The list for each service area should be separately numbered, be in columnar form, and show the name and address of the provider, a succinct statement of the type of service provided (e.g., hospital, pharmacy, physician, gynecology), and the exhibit number of the provider's contract furnished pursuant to Item 13B.

B. Attach a copy of each contract currently in effect between applicant and a provider of health care services. If such contract shows the payment rendered or to be rendered a provider of health care services, such minimum portion of the contract as is necessary to prevent disclosure of such payment shall be deleted or blanked out by suitable means in the copy furnished as an exhibit available for public inspection. An additional unmarked copy of each contract shall be furnished as a confidential exhibit to the applicant, designated with the same exhibit number and clearly marked "confidential."

( )

C. Attach for each service area of the applicant, a list of all contracts currently in effect between applicant and any person for the performance of administrative functions or services for applicant. The list for each service area should be separately numbered, be in columnar form, and show the name and address of such person, a succinct statement of the type of service provided, and the exhibit number of the contract furnished pursuant to Item 13D.

D. Attach a copy of each contract currently in effect between applicant and any person agreeing to perform an administrative function or service for the applicant.

( )

E. Does applicant have any contract or arrangement, written or oral, with any person named in Items 7, 8 or 9, or in any exhibit thereunder, or with a person controlling, controlled by or under common control with applicant?

( ) Yes ( ) No

If "yes," furnish a copy of each such contract (or a description of such contract, if an oral contract) and a list thereof setting forth the name of such person and the exhibit number of such contract. Any contract furnished pursuant to parts "A", "B", "C" or "D" of this item need not be furnished under this part but must be included in the list.

F. Does any person named pursuant to parts "A" or "C" of this item have a financial interest in, or other relationship to, applicant not disclosed pursuant to Items 7, 8 or 9 or any exhibit thereunder?

( ) Yes ( ) No

If "yes," attach an exhibit explaining fully such interest or relationship. For the purpose of this item, "interest or relationship" means any interest or relationship which may indicate an absence of arms-length bargaining on behalf of the applicant with respect to such contract or arrangement.

14. Individual and Group Plan Contracts.

A. Attach a copy of each plan contract (a contract sold to individuals) and each group plan contract which is to be issued by the applicant or which has been issued by the applicant and is currently in effect. If standard form contracts are used, only a specimen of each standard form contract need be submitted, accompanied by a schedule or explanation of the variations which were made, or may be made, in such contracts when issued.

B. Does any plan contract furnished pursuant to Item 14-A fail to provide all of the basic health care services included in Subdivision (b) of Section 1345 of the Act and as defined by Rule 1300.67?

( ) Yes ( ) No

If "yes," attach a complete explanation.

C. 1. If applicant is a health care service plan, furnish as an exhibit a detailed description of each health care service, other than basic health care services, furnished by the plan to subscribers and enrollees.

2. If applicant is a specialized health care service plan, furnish as an exhibit a detailed description of the health care service furnished by the plan.

15. Medi-Cal Participation.

A. Does the applicant have a contract with the California Department of Health under the provisions of the Waxman-Duffy Prepaid Health Plan Act?

( ) Yes ( ) No

B. If "yes," state the date of its current contract and the number of persons enrolled in the plan pursuant thereto:

Date of contract: _____ No. of enrollees: _____

C. If "no" is applicant seeking, or does it intend to seek, such a contract?

( ) Yes ( ) No

16. Health Maintenance Organization Act of 1973.

A. If applicant is not currently qualified under such Act, has it applied for or does it intend to apply for such qualification? ( ) Yes ( ) No

B. Is the applicant a qualified organization under the provisions of such Act?

( ) Yes ( ) No

C. Has applicant received any grants, loans or loan guarantees under the provisions of the Act? ( ) Yes ( ) No

17. Internal Review of Quality of Care.

Attach as an exhibit a description of applicant's procedures and programs for internal review of the quality of health care pursuant to the requirements of the Act.

18. Method of Subscriber-Enrollee Participation in Plan Policy.

Attach as an exhibit a description of the mechanism by which enrollees and subscribers will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan, pursuant to Section 1369 of the Act.

19. Subscriber-Enrollee Grievance Procedure.
    A. Attach as an exhibit a description of the enrollee-subscriber grievance procedure to be utilized as required by Section 1368 of the Act.
    B. Attach as an exhibit a copy of the complaint form proposed to be used by the applicant pursuant to Section 1368(c) of the Act.
20. Insurance Coverages.
    The following should be attached as exhibits to the application.
    A. Furnish evidence that applicant maintains adequate insurance or self-insurance to respond to claims against applicant for damages arising out of the furnishing of health care services.
    B. Furnish evidence that applicant maintains adequate insurance, or self-insurance, to cover its liabilities for tort claims, other than with respect to claims for damages arising out of the furnishing of health care services.
    C. Furnish evidence that applicant maintains adequate insurance coverage or self-insurance to protect against losses of facilities upon which it has the risk of loss due to fire or other causes. Identify facilities covered by individual policies and indicate the basis upon which applicant believes that the insurance thereon is adequate.
    D. Identify all facilities described in Item 12 upon which applicant has the risk of loss due to fire or other causes which are not covered by the information provided in response to "C" above and explain the failure to provide such insurance, including if pertinent a description of currently effective insurance maintained by others upon such facilities and whether such coverage is required pursuant to a contract with the applicant.
    E. File a copy of the fidelity bond obtained by applicant pursuant to Rule 1300.76.3.
    F. Furnish evidence of adequate workmen's compensation insurance coverage against claims which may arise against applicant.
21. Evidence of Coverage, Disclosure Materials.
    A. Furnish a copy of each form of evidence of coverage which is currently used by applicant or which applicant proposes to use.
    B. Furnish a copy of each disclosure form which is currently used by the applicant or which applicant proposes to use.
22. Financial Information.
    A. Attach as an exhibit a copy of applicant's financial statements, consisting of at least a balance sheet and statement of income and expenses, prepared as of a date within 90 days of the filing of this application. This statement need not be certified, but *if not* certified, also attach as an exhibit its most recent certified financial statements of the applicant as of the close of its last fiscal year.
    B. Attach as an exhibit a calculation of applicant's tangible net equity prepared in accordance with Rule 1300.76.
    C. Attach as an exhibit a schedule of the rates and charges adopted by the applicant.
    D. Attach an exhibit fully describing the method used by the applicant to determine the rates and charges to individual and to group subscribers.
    E. Does applicant:
        1. Reimburse providers of health care services that do not contract in writing with the plan to provide health care services for a specified consideration?
        ( ) Yes ( ) No

2. Reimburse its subscriber-enrollees for expenditures incurred in having received health care services from providers that do not contract with applicant?
( ) Yes ( ) No
3. Reimburse providers of health care services on a fee-for-service basis?
( ) Yes ( ) No

If any of the above is answered "yes" state the percent which such reimbursements are of the applicant's total expenditures for health care services during each calendar quarter of the preceding two calendar years (or if applicant has not operated for two years or has not made such reimbursements for that period, for such lesser period).

F. If the amount of reimbursements reported pursuant to item E-1 and/or E-2 above exceeds 10 percent, answer the following questions.
1. Does applicant maintain cash or cash equivalents at least equal to the aggregate sum of the last four months of reimbursable payments which were made and accrued to such providers of service and its subscribers and enrollees?
( ) Yes ( ) No
2. Does applicant maintain adequate insurance to compensate for any loss resulting from the insolvency of the applicant? ( ) Yes ( ) No

If "yes" furnish a complete description of such insurance and evidence that such insurance is currently in effect.

G. Attach a narrative statement describing the applicant's approach to fiscal soundness and the provisions made relative to its ability to meet its contractual obligations in respect to the risk of insolvency. The presentation should include the following:
a. Projections on a quarterly basis for the ensuing year covering enrollments, the utilization of health services and expenditures therefore by major category, administrative expenses, debt servicing requirements, cash flow and sources of funds. Such projections should be accompanied by a written statement of the assumptions related thereto and the basis for assuming their validity.
b. The complete results of feasibility studies, as normally required by conventional lending institutions, in each of these areas: legal, market/enrollment, providers and financial.
c. Describe the approach and specific provisions made against the risk of insolvency including, but not limited to, any risk-taking or insurance arrangements with outside organizations. (See Subsections (b) and (c) of Section 1300.75.3.)

H. Is applicant engaged in any business other than the operation of the plan?
( ) Yes ( ) No

If "yes" attach an exhibit fully describing such other business.

23. Marketing of Plan Contracts.
A. Attach an exhibit describing the method(s) by which applicant proposes to market plan contracts, including the method of compensation to employees and outside solicitors for sales.
B. Attach an exhibit demonstrating the plan's compliance and provisions for ongoing compliance with Section 1300.59.
C. Attach as an exhibit, a copy of each form or agreement which will be shown to or completed by subscribers or enrollees (other than forms submitted pursuant to Item 22).
D. 1. Attach as an exhibit a copy of each form of contract or proposed contract, including employment contract, between applicant and any person agreeing to solicit on behalf of applicant.
2. Attach a list showing the name and address of each person who contracts to engage in solicitation on behalf of the applicant, identifying each as a solicitor or a solicitor firm, as defined in Section 1345(*l*) and (m) of the Act. Persons licensed by the California Insurance Commissioner must be so identified.

E. Name and address of applicant's officer, management or supervisory employee who will supervise the solicitation of plan sales.

(Name) (Title)

(Address)

24. Exhibits.

Attach the following exhibits to the application, numbering each exhibit by the item number of letter indicated below. If any exhibit is not applicable, so indicate by marking the appropriate box.

	Exhibits Not Applicable
A. A copy of each of the basic organizational documents of the applicant, such as the articles of incorporation, association or partnership, trust agreement, and all amendments thereto.	( )
B. A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.	( )
C. A Consent to Service of Process, if applicant is other than a California corporation (Form HP1351-J).	( )
D. A list setting forth the name, business address, and license number of each physician employed by or contracting with the applicant to provide medical services, to the extent that this does not duplicate information required by Item 13A. Such list should be furnished by service area and the names listed alphabetically.	( )

CALIFORNIA
DEPARTMENT OF CORPORATIONS
EXHIBIT 7-A to APPLICATION FOR HEALTH PLAN LICENSE
For Corporations.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A) _____

2. State of Incorporation. 3. Date of Incorporation.

4. Is applicant a nonprofit corporation? ( ) Yes ( ) No

5. Is applicant exempted from taxation as a nonprofit corporation? ( ) Yes ( ) No

6. Names of principal officers, directors and shareholders: List (a) each person who is a director or principal officer or who performs similar functions or duties and (b) each person who holds of record or beneficially over 5% of the voting securities of applicant or over 5% of applicant's equity securities. If this is an amended exhibit, place an asterisk (*) before the names for whom a change in title, status or stock ownership is being reported and a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Relationship		Class of Equity Security	Percent of Class
Last	First	Middle	Beginning Date Mo. Year	Title or Status		

7. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

CALIFORNIA
DEPARTMENT OF CORPORATIONS
EXHIBIT 7-B to APPLICATION FOR HEALTH PLAN LICENSE
For Partnerships.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A).

2. State of organization. 3. Date of organization.

4. Names of Partners and Principal Management: List all general, limited and special partners and all persons who perform principal management functions. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title, status or partnership interest is being reported and place a double asterisk (**) before the names of persons which are added to those furnished in the most recent previous filing.

Full Name			Beginning Date	Type of Partner	Capital Contribution	Title or Duties
Last	First	Middle	Mo. Year		(%)	

5. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

CALIFORNIA
DEPARTMENT OF CORPORATIONS

EXHIBIT 7-C to APPLICATION FOR HEALTH PLAN LICENSE

For Sole Proprietorship.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A).

2. Residence Address.

3. Names of persons performing principal management functions: List each person who occupies a principal management position or who performs principal management functions for the applicant. If this is an amended exhibit, place an asterisk (*) before the names of persons for whom a change in title or duties is being reported and place a double asterisk (**) before the names of persons which are being added to those furnished in the most recent previous filing of this exhibit.

Full Name			Beginning date	Title and Duties
Last	First	Middle	Mo. Year	

4. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

CALIFORNIA
DEPARTMENT OF CORPORATIONS
EXHIBIT 7-D to APPLICATION FOR HEALTH PLAN LICENSE
For organizations other than corporations, partnerships and sole proprietorships.
To be used in response to Item 7 of Form HP 1300.51.

1. Name of Applicant (as in Item 1-A)

2. State of Organization 3. Date of Organization

4. Form of Organization (describe briefly)

5. Names of Principal Officers and Beneficial Owners: List below the names of (a) each person who is a principal officer or trustee of the applicant or who performs principal management functions, and (b) each person who owns of record or beneficially over 5% of any class of equity security of the applicant. If this is an amended exhibit, place an asterisk (*) before the name of each person for whom a change in title, status or interest is reported, and a double asterisk (**) before the name of persons which are added to those reported in the most recent previous filing.

Full Name			Beginning Date	Class of Equity	Percent of	Title and
Last	First	Middle	Mo. Year	Security	Class	Duties

6. If this is an amended exhibit, list below the names reported in the most recent filing of this exhibit which are deleted by this amendment:

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code.

HISTORY:

1. Amendment of Item 23-C filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
3. Amendment of Item 23 filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
4. Amendment of Item 22-G filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

1300.51.1. Individual Information Sheet.

An individual information sheet required pursuant to these rules shall be in the following form:

CONFIDENTIAL
See Note to Item 5

DEPARTMENT OF CORPORATIONS
State of California

INDIVIDUAL INFORMATION SHEET
under the
Knox-Keene Health Care Service Plan Act of 1975
(California Health & Safety Code Sec. 1340 et. seq.)

1. Name of Applicant: File No. _____

2. Exact full name of person completing this statement:

First Middle Last

3. Physical Description:
Sex _____ Hair _____ Eyes _____ Height _____ Weight _____
4. Birthdate: _____ Birthplace: _____
5. Social Security No. or
Taxpayer Ident. No: _____

NOTE: The inclusion of your social security number is not required but is voluntary. It is solicited pursuant to Sections 1344 and 1351 of the Health and Safety Code. It may be used to conduct a background investigation by the Department, the California Department of Justice Information Branch, or by other federal, state or local law enforcement agencies. This form, including the social security number, will be held confidential, but is a public record and available to the public pursuant to the Public Records Act (Gov. Code Section 6250), at the discretion of the Commissioner.

6. Residence Telephone: 7. Business Telephone: _____

8. Current Residence Address:

Number and Street City State Zip

9. Employment for the last 5 years (list most recent employment first):

From	To	Employer Name and Address	Occupation and Duties
	Present		

NOTE: Attach separate schedule if space is not adequate.

10. Business contacts and dealings (other than employment indicated in item 9) with plans during the last 5 years (include, for example, such roles as officer, director, stockholder, consultant, manager, provider and supplier, and such dealings as sales, leasing, and any contractual relationships) (list most recent business contacts and dealings first):

From	To	Plan Name and Address	Relationship and Duties

NOTE: Attach separate schedule if space is not adequate.

11. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code or Health and Safety Code denied, revoked or suspended or been otherwise subject to disciplinary action, while you were in the employ of the applicant, or while you had a contract with the applicant as a provider or otherwise? ☐ Yes ☐ No
If "yes" state the date of the action and the administrative body taking such action.

_____

_____

_____

_____

_____

12. Have you ever been convicted or pled *nolo contendere* to a misdemeanor involving moral turpitude or any felony, other thantraffic violations?
☐ Yes ☐ No

If the answer is "yes" give details:

_____

_____

_____

_____

_____

13. Have you ever changed your name or ever been known by any name other than that herein listed? (Including a married person's prior surname, if any.)
☐ Yes ☐ No

If so, explain. Change in name through marriage or court order should also be listed. EXACT DATE OF EACH NAME CHANGE MUST BE LISTED.

_____

_____

14. Have you ever engaged in business under a fictitious firm name either as an individual or in the partnership or corporate form?
☐ Yes ☐ No

If the answer is "yes" set forth particulars:

_____

_____

_____

_____

_____

VERIFICATION

I, the undersigned, state that I am the person named in the foregoing Individual Information Sheet, that I have read and signed said Individual Information Sheet and know the contents thereof, including all exhibits attached thereto; and that the statements made therein, including any exhibits attached thereto, are true.

I certify/declare under penalty of perjury that the foregoing is true and correct.

Executed at _____
City

_____
County State

this _____ day of _____ 19____

_____
(Signature of Declarant)

NOTE: If this form is signed outside California complete the verification before a notary public in the space provided below.

State of _____
County of _____
Dated _____, 19____
at _____

_____
(Signature of Affiant)

Subscribed and sworn to before me ____, 19____

_____
Notary Public in and for said County and State

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code.

HISTORY:

1. Amendment filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

1300.51.2. Consent to Service of Process.

The consent to service of process required pursuant to these rules shall be in the following form:

TO THE COMMISSIONER OF CORPORATIONS OF
THE STATE OF CALIFORNIA

CONSENT TO SERVICE OF PROCESS

KNOW ALL MEN BY THESE PRESENTS:

That the undersigned, _____,
(a corporation organized under the laws of the State of _____)
(a partnership) (an individual) (other _____)
hereby irrevocably appoints the Commissioner of Corporations of the State of California, or his successor in office, to be his (its) attorney to receive service of any lawful process in any noncriminal suit, action or proceeding against him (it), or his (its) successor, executor, or administrator which arises under the Knox-Keene Health Care Service Plan Act of 1975 or any rule or order thereunder after this consent has been filed, with the same force and validity as if served personally on the undersigned.

For the purpose of compliance with the Corporations Code of the State of California, notice of the service and a copy of the process should be sent by registered or certified mail to the undersigned at the following address:

Name

Street Address

City State Zip Code

Dated: _____, 19____.

By _____
Title _____

CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT

STATE OF _____
COUNTY OF _____

On this _____ day of _____, 19____, before me, _____, the undersigned officer, personally appeared _____ known personally to me to be the _____ of the above-named corporation (partnership), and that he, as such officer (general partner), being authorized so to do, executed the foregoing instrument for the purposes therein set forth, by signing the name of the corporation (partnership) by him as such officer (partner).

IN WITNESS WHEREOF I have hereunto set my hand and official seal.

My Commission expires Notary Public

INDIVIDUAL ACKNOWLEDGMENT

STATE OF _____
COUNTY OF _____

On this _____ day of _____, 19____, before me, _____, the undersigned officer, personally appeared _____ to me personally known and known to me to be the same person(s) whose name(s) is (are) signed to the foregoing instrument, and acknowledged the execution thereof for the purposes therein set forth.

IN WITNESS WHEREOF I have hereunto set my hand and official seal.

My Commission expires Notary Public

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1351, Health and Safety Code.

HISTORY:

1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.52. Amendments to Plan Application.

An amendment to a plan application pursuant to subdivision (a) of Section 1352 of the Act shall be filed upon the form contained in Section 1300.51 and shall consist of (1) a completed Execution Page and (2) each page and/or each exhibit to the application which is amended. The Execution Page, each page of the application and each page of an exhibit submitted as part of an amendment shall be completed as to all items required to be stated therein, including information which is not changed by the amendment. The changed portions of each application page and exhibit shall be indicated in the manner specified in the instructions to the application form.

1300.52.1. Notice of Material Modification.

A notice of material modification of its operations or of any plan contract pursuant to subdivision (b) of Section 1352 of the Act shall be filed as an amendment to the application as provided in Section 1300.52, and there shall be attached to such amendment, preceding the Execution Page, the following form:

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

NOTICE OF MATERIAL MODIFICATION
Pursuant to
Health and Safety Code Sec. 1352(b)

1. Name of applicant: _____
2. Department of Corporations File Number: _____
3. The fee for filing this application will be forwarded upon receipt of the billing therefore from the Commissioner of Corporations, pursuant to Health and Safety Code Section 1352(d).
4. Pursuant to Subdivision (b) of Section 1352 of the Health and Safety Code, applicant requests approval of the material modification of its plan and/or operations, within the time specified below:
   (Check appropriate box)
   ( ) Within the 20 business-day period provided in Section 1352(b).
   ( ) Applicant extends the time for action upon this notice by the Commissioner until _____.
   ( ) Applicant requests accelerated approval by the Commissioner for the following reasons:

_____
_____
_____
_____
_____

Date: _____ _____
Signature of Authorized Officer

_____
Title

1300.52.2. Change in Plan Personnel.

Pursuant to subdivision (c) of Section 1352 of the Act, a plan shall file an amendment to its applications in the form required by Section 1300.52, when there are any of the following changes in personnel of the plan, of any management company of the plan, or of any parent company of such plan or management company:

(a) There is an addition or deletion of a director, trustee, principal officer, general partner, general manager or principal management persons, or persons occupying similar positions or performing similar functions, or a substantial and material change in the duties of any such person.

(b) There is the addition or deletion of a limited partner, shareholder or owner of an equity interest in the plan, whose interest exceeds 5 percent of the total partnership interests, shares or equity interests, or there is a change in the interest of any partner, shareholder or owner of an equity interest exceeding 5 percent of the total partnership interests, shares or equity interests.

(c) There is the addition or deletion of a principal creditor, as defined in Section 1300.45, a material change in the terms of the obligation to a principal creditor, a material increase or decrease in the amount due a principal creditor other than (except in the case of a demand obligation) by the normal terms of the obligation, or a default in the obligation to a principal creditor.

1300.52.3. Filings and Actions Relating to Charitable or Public Activities.

(a) Amendments to a plan application or notices of material modifications filed pursuant to Section 1352 or any other reports or filings under the Act shall not be deemed to be notices or requests for approval or ruling pursuant to Article 2, Part 11, Division 2, Title 1 of the Corporations Code or special reports pursuant to Section 1300.84.7, nor shall any such notices or requests for approval or ruling or special reports be deemed to be amendments to a plan application or notices of material modifications of a plan or its operations pursuant to Section 1352 or other reports or filings under the Act. However, this section shall not prevent a plan from filing notices or requests pursuant to Article 2 (commencing with Section 10820), Part 11, Division 2, Title 1 of the Corporations Code and/or special reports pursuant to Section 1300.84.7 concurrently with materials being filed under Section 1352 and utilizing common exhibits, subject to the provisions of Section 1300.824(c).

(b) Orders and other actions of the Commissioner pursuant to Section 1352 or other provision of the Act, and the effects thereof, are limited to the effects contemplated under the Act and are of no effect or consequence in connection with any other law administered by the Commissioner. Similarly, actions of the Commissioner under any other law are of no effect or consequence in relation to Section 1352 or other provision of the Act.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1352, Health and Safety Code.

HISTORY:

1. New section filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).

Article 4. Solicitors

1300.57. Solicitor Application.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1357 and 1358, Health and Safety Code.

HISTORY:

1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.57.1. Solicitor Firm Application by Person Not Licensed by Insurance Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1357, Health and Safety Code.

HISTORY:

1. Amendment filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.57.2. Amendment to Solicitor Firm Application.

HISTORY:

1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.57.3. Fees Payable by Licensed Insurance Agents and Brokers.

HISTORY:

1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.57.4. Solicitor Financial Records Authorization.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1357, Health and Safety Code.

HISTORY:

1. New section filed 11-9-77 as an emergency; effective upon filing (Register 77, No. 46).
2. Certificate of Compliance filed 2-6-78 (Register 78, No. 6).
3. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.59. Plan Assurances Prior to Solicitation.

Prior to allowing any person to engage in acts of solicitation on its behalf, each plan shall reasonably assure itself that such person has sufficient knowledge of its organization, procedures, plan contracts, and the provisions of the Act and these rules to do so lawfully.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1359, Health and Safety Code.

HISTORY:

1. Repealer and new section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.59.1. Examination Fee.

HISTORY:

1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.59.2. Waiver of Examination Requirements.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1359, Health and Safety Code.

HISTORY:

1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

Article 5. Advertising and Disclosure

1300.61. Filing of Advertising and Disclosure Forms.

(a) Two copies of a proposed advertisement shall be filed. An advertisement is "filed" within the meaning of Section 1361 of the Act when a true copy thereof, accurately showing the final appearance of the advertisement, is received. To minimize the expense of changes in advertising copy, it may be submitted in draft form for preliminary review subject to the later filing of a proof or final copy, and the later filing of a proof or final copy may be waived when the draft copy is presented in a manner reasonably representing the final appearance of the advertisement. The text of audio or audio/visual advertising should indicate any directions for presentation, including voice qualities and the juxtaposition of the visual materials with the text.

(b) The Commissioner will not issue letters of nondisapproval of advertising. If the person submitting the advertisement requests an order shortening the 30-day waiting period under Section 1361 of the Act, such order will be issued when an appropriate showing of the need therefor is made.

1300.61.1. Exempt Advertising.

HISTORY:

1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.61.3. Deceptive Advertising.

Without limitation upon the meaning of subdivision (a) of Section 1352.1 and subdivisions (a) and (c) of Section 1361 of the Act, an advertisement or other consumer information is untrue, misleading or deceptive if:

(a) It represents that reimbursement is provided in full for the charge for services, unless the payment by the plan fully satisfies the liability to the provider.

(b) It represents that reimbursement is provided for the customary charges for services, unless the actual experience of the plan is that there is no balance billed for covered services.

(c) It represents that the plan, solicitor firm or solicitor or any provider or other person associated therewith is licensed or regulated by the Department of Corporations or other governmental agency, unless such statement is required by law or regulation or unless such statement is accompanied by a satisfactory statement which counters any inference that such licensing or regulation is an assurance of financial soundness or the quality or extent of services. The phrase "a federally qualified health maintenance organization" and equivalent terms shall not be deemed deceptive advertising when used to refer to an organization which is so qualified under the Health Maintenance Organization Act of 1973. The display, on a plan contract which supplements Medicare with hospital or medical coverage, of the particular emblem approved by the federal Department of Health and Human Services and indicating that such contract meets the certification requirements of 42 U.S.C. 1395ss and the regulations of the Health Care Financing Administration thereunder, or, in lieu of such emblem, of such information, if any, regarding certification as may be approved in writing as to form and content by the Commissioner, shall not be deemed deceptive when (1) the Commissioner has found that such contract complies with the provisions of the Act and these rules and by written notification has authorized the plan to so display such emblem or, in lieu of such emblem, such expressly approved information, if any, regarding certification and has not revoked such authorization, and (2) such contract, and any related disclosure form, evidence of coverage, printed material, and advertising, contains no untrue information regarding the emblem and does not otherwise violate this subsection.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352.1, 1360 and 1361, Health and Safety Code.

HISTORY:

1. New subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.63. Disclosure Form.

(a) The disclosure form required under subdivision (a) of Section 1363 of the Act shall conform to the following requirements.

(1) The text shall be printed in at least 10-point block type. Titles and captions shall be in at least 12-point to 15-point bold face type.

(2) It shall be written in clear, concise, easily understood language.

(3) It should relate to one form of plan contract; however, disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(4) It shall be presented in an easily readable format.

(b) The disclosure form shall be arranged and captioned in the following manner, except as may otherwise be permitted by the Commissioner.

(1) The name of the plan and, if necessary, a designation of the plan contract described in the form.

(2) The title of the form (e.g., "disclosure form", "summary of contract provisions").

(3) A statement in at least 10-point bold face type to the effect that the disclosure form is a summary only and that the plan contract itself should be consulted to determine the governing contractual provisions.

(4) A statement to the effect that a specimen copy of the plan contract will be furnished on request.

(5) The caption "Principal Benefits and Coverages", followed by a description of such benefits and coverages.

(6) The caption "Principal Exclusions and Limitations on Benefits", followed by a description of the principal exclusions, exceptions, reductions and limitations that apply, and arranged in a uniform manner with the preceding section of the form.

(7) The caption "Prepayments Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(8) The caption "Other Charges", followed by a description of each copayment, co-insurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(9) The caption "Choice of Physicians and Providers", followed by a description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(10) If applicable, the caption "Reimbursement Provisions", followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(11) The caption "Facilities", followed by a statement of the principal facilities available under the plan contract, including their location and a description of the services, provided. The hours of availability of both emergency and nonemergency services should be indicated, either specifically or by general description. However, if the Commissioner approves in advance, a plan may provide a telephone number from which information as to the identity and location of provider facilities defined in subsection (i) (2) of Section 1300.45 may be obtained, in lieu of listing such provider facilities.

(12) The caption "Renewal Provisions", followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(13) In the case of group contracts, the caption "Individual Continuation of Benefits", followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to Subdivision (g) of Section 1373 of the Act.

(14) The caption "Termination of Benefits", followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(c) In the event the receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the disclosure form may be required by the Commissioner to disclose such facts.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.63.1. Evidence of Coverage.

(a) Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either an evidence of coverage or a copy of the plan contract, which shall conform to the requirements of this section. The Commissioner may permit the evidence of coverage and the disclosure form prescribed by Section 1300.63 to be presented in a single document if the purposes of each are fulfilled.

(b) Except as may be otherwise permitted by the Commissioner, the evidence of coverage shall conform to the requirements of subsection (a) of Section 1300.63 and the following requirements:

(1) It shall be clearly entitled "Evidence of Coverage".

(2) The portions of the text specifying (1) limitations, exclusions, exceptions and reductions; (2) rights of cancellation; (3) restrictions on renewal or reinstatement; (4) rights of the health plan to change benefits; (5) subsequent providers; and (6) liability of members in the event of nonpayment by the health plan, shall be in type not less than 2 points larger than the text relating to other provisions and in no event less than 12 point type.

(3) It shall be divided into sections, each of which shall have a title identifying the nature of the information contained therein.

(4) The evidence of coverage when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c) The evidence of coverage shall contain at a minimum the following information:

(1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(3) The manner in which the member can determine who is or may be entitled to benefits.

(4) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(5) The time and date or occurrence upon which coverage will terminate.

(6) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Commissioner.

(7) The conditions for and any restrictions upon the member's right to renewal or reinstatement.

(8) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(9) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(10) A statement of any restriction on assignment of sums payable to the member by the health plan.

(11) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed and the address at or to which it shall be delivered or mailed.

(12) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(13) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(14) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(15) A statement to the effect that in the event the health plan fails to pay a noncontracting provider, the member may be liable to the noncontracting provider for the cost of the services.

(16) An appropriate statement to fulfill the requirement of Section 1300.69(i)(1), unless the plan undertakes to mail such information annually.

(17) A statement which shall be set forth in boldface type not less than 2 points larger than the type required by subsection (b)(2): "This evidence of coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1360 and 1363, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c)(16) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (c) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.63.2. Combined Evidence of Coverage and Disclosure Form.

Notwithstanding Sections 1300.63 and 1300.63.1 of these rules, a plan may combine the evidence of coverage and disclosure form into a single document if such plan complies with each of the following requirements:

(a) Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either a single document consisting of a combined evidence of coverage and disclosure form or a copy of the plan contract, which shall conform to the requirements of this section.

(b) Except as may be otherwise permitted by the Commissioner, the combined evidence of coverage and disclosure form shall conform to the following requirements:

(1) It shall be clearly entitled "Combined Evidence of Coverage and Disclosure Form".

(2) The text shall be printed in at least ten point block type. Titles and captions shall be in at least twelve point to fifteen point boldface type.

(3) It shall be written in clear, concise, easily understood language.

(4) It should relate to one form of plan contract; however, combined evidence of coverage and disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(5) It shall be presented in an easily readable format.

(6) The combined evidence of coverage and disclosure form when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c) The combined evidence of coverage and disclosure form shall contain at a minimum the following information:

(1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) A statement that the specimen of the plan contract will be furnished on request.

(3) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(4) The manner in which the member can determine who is or may be entitled to benefits, except that a member under group coverage may be referred to the group contract holder for such information.

(5) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(6) The time and date or occurrence upon which coverage will terminate.

(7) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Commissioner.

(8) The conditions for and any restrictions upon the member's right to renewal or reinstatement.

(9) The caption "Prepayment Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(10) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(11) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(12) The caption "Other Charges", followed by a description of each copayment, coinsurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(13) A statement of any restriction on assignment of sums payable to the member by the health plan.

(14) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed.

(15) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(16) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(17) The caption "Choice of Physicians and Providers", followed by description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(18) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(19) A statement to the effect that in the event the health plan fails to pay noncontracting providers, the member may be liable to the noncontracting provider for the cost of services.

(20) If applicable, the caption "Reimbursement Provisions", followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(21) The caption "Renewal Provisions", followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, as appropriate, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(22) The caption "Facilities", followed by a statement of the principal facilities available under the plan contract, including their location and description of the services provided. The hours of availability of both emergency and non-emergency services should be indicated, either specifically or by general description. However, if the Commissioner approves in advance, a plan may provide a telephone number from which information as to the identity and location of the provider facilities defined in subsection (i) (2) of Section 1300.45 of these rules may be obtained, in lieu of listing such provider facilities.

(23) In the case of group contracts, the caption "Individual Continuation of Benefits", followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to subdivision (g) of Section 1373 of the Act.

(24) The caption "Termination of Benefits", followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(25) Any appropriate statement to fulfill the requirement of Section 1300.69 (i) (1) of these rules, unless the plan undertakes to mail such information annually.

(26) In the event that receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the combined evidence of coverage and disclosure form may be required by the Commissioner to disclose such facts.

(27) A statement which shall be set forth in boldface type not less than two points larger than the type required by subsection (b) (2): "This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1360, 1363 and 1368, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82, effective thirtieth day thereafter (Register 82, No. 33).

1300.63.3. Experimental Disclosure.

Notwithstanding those provisions of Sections 1300.63, 1300.63.1, 1300.63.2, and 1300.67.4 which require the use of any particular type size, boldface type, caption, subcaption, heading, design, order, or format, the Commissioner by order may approve, for experimental use, reasonable alternatives to such requirements for a disclosure form, evidence of coverage, combined evidence of coverage and disclosure form, or plan contract upon the written request of a plan, for such period and under such conditions as the Commissioner may specify, subject to each of the following conditions:

(a) That the plan submits two draft copies of the document containing the proposed alternatives, one as proposed to be used and the other redlined to highlight the proposed changes, along with two copies of the related plan contract, at least 30 days prior to any use of the document, or such shorter period as the Commissioner by order may allow.

(b) That the plan demonstrates to the satisfaction of the Commissioner that the document containing the proposed alternatives furthers the purposes of the Act, otherwise complies with the Act and the rules thereunder, and will provide to actual or potential subscribers or enrollees (as the case may be) unobjectionable information at least as clear, concise, accurate, easily understood, and easily readable as could otherwise be achieved.

(c) That the plan submits a proof or final copy of the document at such time, not to exceed 30 days, prior to its initial use as may be specified by the Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

HISTORY:

1. New section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.63.50. Medicare Supplement Additional Disclosure.

(a) The disclosure form required pursuant to Section 1363 of the Act and Section 1300.63 of these rules, if it relates to a contract which is not a contract of a federally qualified health maintenance organization and which primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage shall also set forth the following information in the format indicated:

(1) With the information required by item (1) of subsection (b) of Section 1300.63 of these rules, conspicuously identify, on the first page of the disclosure form immediately under the plan name, the disclosure form as being for the plan's Medicare supplement contract (if such contract is in compliance with the Act and these rules).

(2) If the Medicare supplement contract is issued on a basis not identical to that described in the disclosure form previously provided, a corrected disclosure form shall also be provided in accordance with Section 1363 of the Act when the contract is delivered and shall contain the following statement, in no less than twelve (12) point type on the first page, immediately above the company name:

"NOTICE: Read this disclosure form carefully. It is not identical to the disclosure form previously provided and the coverage originally applied for has not been issued."

(3) Immediately after item (4) and immediately preceding item (5) of subsection (b) of Section 1300.63 of these rules, the following information substantially in the form prescribed below:

(A) Read Your Contract Carefully. This outline of coverage provides a very brief description of the important features of your plan contract. This is not the plan contract and only the actual contract provisions will control. The plan contract itself sets forth in detail the rights and obligations of both you and (insert the health care service plan's name). It is, therefore, important that you READ YOUR CONTRACT CAREFULLY!

(B) Medicare Supplement Coverage. Contracts of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient services and some physician services subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the contract. The contract does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(Next page is 1300.24.3)

(C) Neither (insert the health care service plan's name) nor its agents are connected with Medicare.

(4) With the information required by item (5) of subsection (b) of Section 1300.63 of these rules include, with a caption substantially as follows, a brief summary of the then current major benefit gaps in Medicare parts A and B, including dollar amounts, with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement contract in the following order:

Service	Benefit	Medicare Provides	This Contract Provides	You Pay
HOSPITALIZATION semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $(__)		
	61st to 90th day a day	All but $(__)		
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services	91st to 150th day	All but $(__) a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE . . .	First 20 days	100% of costs		
In a facility approved by Medicare, you must have been in a hospital for at least 3 days and enter the facility within 14 days after hospital discharge.	Additional 80 days	All but $(__) a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge (after $(__) deductible)		

(5) With the information required by item (6) of subsection (b) of Section 1300.63 of these rules also include:

(A) A statement that the plan contract does or does not cover the following:

1. Private duty nursing,
2. Skilled nursing home care costs (beyond what is covered by Medicare),
3. Custodial nursing home care costs,
4. Intermediate nursing home care costs,
5. Home health care above number of visits covered by Medicare,
6. Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),
7. Care received outside of U.S.A.,
8. Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(B) A description of any plan contract provisions which delay or in any other manner operate to qualify the provision or payment of any benefits described in the benefit summary required by item (4) of this subsection.

(C) A statement that the chart summarizing Medicare benefits only briefly describes such benefits and that the Health Care Financing Administration of the federal Department of Health and Human Services or its Medicare publications should be consulted for further details and limitations applicable to Medicare.

(b) Notwithstanding the provisions of Section 1300.63.2 of these rules, no plan shall combine the evidence of coverage and disclosure form into a single document relating to a contract which supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage unless it also complies with the following requirements:

(1) With the information required by item (1) of subsection (c) of Section 1300.63.2 of these rules, provide the information required by item (1) of subsection (a) of this section.

(2) If the Medicare supplement contract is issued on a basis not identical to that described in the combined evidence of coverage and disclosure form previously provided, a corrected combined document shall be provided in accordance with Section 1363 of the Act and Section 1300.63.2 of these rules when the contract is delivered and shall contain the following statement, in no less than twelve (12) point type on the first page, immediately above the company name:

"NOTICE: Read this document carefully. It is not identical to the combined evidence of coverage and disclosure form previously provided and the coverage originally applied for has not been issued."

(3) Immediately after item (3) and immediately preceding item (4) of subsection (c) of Section 1300.63.2 of these rules, provide the information required by item (3) of subsection (a) of this section.

(4) With the information required by item (11) of subsection (c) of Section 1300.63.2 of these rules, provide the information required by items (4) and (5) of subsection (a) of this section.

(c) Notwithstanding the provisions of this section, a plan shall not be required to comply with the provisions of this section with respect to any group contract which is:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations, or

(2) A group contract with any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of such contract to its members.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.64.50. Medicare Supplement Application Information.

(a) In the interest of full and fair disclosure, and to assure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, and Medicare supplement contracts, each health care service plan which is not a federally qualified health maintenance organization or other plan organized and operated exclusively as a health maintenance organization (staff model, group practice model, or individual practice association model) and which offers any contract which primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage on a reimbursement basis shall comply with the provisions of this section.

(b) The application form for persons eligible for Medicare used by a plan described in subsection (a) shall include a question designed to elicit information as to whether a Medicare supplement contract is intended to replace any accident and sickness policy or certificate or plan contract presently in force. A supplementary application or other form to be signed by the applicant containing such question may be used.

(c) Upon determining that a sale will involve replacement, a plan described in subsection (a), other than a plan selling as a result of direct response solicitation (as indicated below), or its agent shall furnish the applicant, prior to issuance or delivery of the Medicare supplement contract, a notice regarding replacement of existing coverage. One copy of such notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the plan. However, a plan described in subsection (a) which is selling as a result of direct response solicitation (i.e., solicitation through the news media or the mail) shall deliver to the applicant at the time of issuance of the contract a notice regarding replacement of coverage. The notice required by this subsection shall be provided in substantially the form set forth in subsection (d), except that a plan selling as a result of direct response solicitation shall modify such form as required by subsection (e).

(d) The notice required by this subsection shall be provided in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS COVERAGE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate an existing accident and sickness insurance policy or plan contract and replace it with a contract to be issued by (Plan Name). Your plan contract to be issued by (Plan Name) provides thirty (30) days within which you may decide without cost whether you desire to keep the contract. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage available to you under the new contract.

(1) You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.

(2) You may wish to secure the advice of your present insurer or plan or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical/health history. Failure to include all material medical information on an application requesting such information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(e) A plan selling as a result of direct response solicitation (i.e., solicitation through the news media or the mail) shall modify the form set forth in subsection (d) by deleting the statement acknowledging delivery and the provision for the date and the applicant's signature, and by using, in lieu of item (3) of said notice, a provision in substantially the following form:

(3) (To be included only if the application is attached to the contract.) If, after due consideration, you still wish to terminate your present policy or contract and replace it with new coverage, read the copy of the application attached to your new contract and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Plan Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Plan Name)

(f) Notwithstanding the provisions of this section, a plan shall not be required to comply with the provisions of this section with respect to any group contract which is:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations, or

(2) A group contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of such contract to its members.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1364, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.64.51. Medicare Supplement "Buyer's Guide".

(a) In the interest of full and fair disclosure, and to assure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, and Medicare supplement contracts, each health care service plan which is not a federally qualified health maintenance organization or other plan organized and operated exclusively as a health maintenance organization (staff model, group practice model, or individual practice association model) and which offers any contract which primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage on a reimbursement basis shall comply with the provisions of subdivision (b).

(b) The application form or other consumer information for persons eligible for Medicare and used by a plan described in subdivision (a) shall contain as an attachment a Medicare supplement "buyer's guide" in the form approved by the Commissioner. Such application or other consumer information, containing as an attachment the "buyer's guide", shall be mailed or delivered to each person applying for such coverage at or before the time of application and, to establish compliance with this subdivision, the plan shall obtain an acknowledgement of receipt of the attached "buyer's guide" from each applicant. No plan shall be required to provide more than one copy of the "buyer's guide" to any applicant.

(c) A plan may comply with the requirement of this section in the case of group contracts by causing the group contract holder

(1) to disseminate copies of the disclosure form containing as an attachment the "buyer's guide" to all persons eligible under the group contract at the time such persons are offered the plan, and

(2) collecting and forwarding to the plan an acknowledgement of receipt of the disclosure form containing as an attachment the "buyer's guide" from each person described in item (1).

(d) Notwithstanding the provisions of this section, a plan shall not be required to comply with the provisions of this section with respect to any group contract which is:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations, or

(2) A group contract with any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of such contract to its members.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1364, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

Article 6. Appeals on Cancellation

1300.65. Cancellation of Enrollment.

(a) For the purposes of subdivision (a) (3) of Section 1365 of the Act, "good cause" means a cause for cancellation or failure to renew which the Commissioner has not found to be objectionable by regulation.

(b) In the event that the plan cancels or refuses to renew a plan contract, or a subscription or enrollment thereunder, the plan shall mail a notice of cancellation to the subscriber at the subscriber's address of record with the plan. However, in the event that the plan cancels or refuses to renew a group contract, the plan need not mail a notice of cancellation to each subscriber thereunder if: (1) the plan contract requires the group contract holder to mail promptly any such notice to each subscriber, (2) the plan mails or hand delivers a notice of cancellation to the group contract holder designated in the plan contract, and (3) the plan demonstrates that the group contract holder promptly mailed a legible, true copy of the notice of cancellation to each subscriber at the subscriber's current address and promptly provided proof of such mailing and the date thereof to the plan. Unless the plan contract otherwise provides, a notice of cancellation pursuant to subdivision (a) (2) of Section 1365 of the Act may be effective upon mailing to the subscriber, and a notice of cancellation pursuant to subdivision (a) (3) may be effective 15 days after the notice is mailed to the subscriber. This subsection is not applicable to a loss of eligibility for Medi-Cal benefits.

(c) A notice of cancellation must be in writing and dated, and must state

(1) the cause for cancellation, with specific reference to the clause of the plan contract giving rise to the right of cancellation,

(2) that the cause for cancellation was not the enrollee's or subscriber's health status or requirements for health care services,

(3) the time when the cancellation is effective in accordance with the provisions of subsection (b) or Medi-Cal requirements, as appropriate, and

(4) that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Commissioner.

(d) A plan which refuses to renew a subscription or enrollment shall give notice to the person seeking such renewal substantially in the form and content required by subsection (c), except where nonrenewal or nonenrollment is based on avoidance of duplication of coverage where the subscriber or applicant has become eligible for Medi-Care benefits.

(e) The terms "cancellation" and "failure to renew", for the purposes of Section 1365 of the Act, do not include a voluntary termination by a subscriber or the termination of a plan contract which does not contain a renewal provision.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.65.1. Cancellation Complaint Form.

(a) A request that the Commissioner review cancellation of, or refusal to renew, an enrollment or subscription pursuant to subdivision (b) of Section 1365 of the Act shall be made in writing, signed by the subscriber or enrollee or the legal representative of the subscriber or enrollee and it shall be in the following form (or in letter form containing the information specified in the form below):

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

TO: Health Care Service Plan Division
Department of Corporations
600 South Commonwealth Avenue
Los Angeles, CA 90005

Date:_____

RE: COMPLAINT ON CANCELLATION OF, OR REFUSAL TO RENEW, HEALTH CARE SERVICE PLAN BENEFITS.

The undersigned requests that the Commissioner review the cancellation or refusal to renew the subscription or enrollment for health plan benefits pursuant to Section 1365 of the Knox-Keene Health Care Service Plan Act of 1975, as follows:

1. Name of person whose benefits were cancelled or not renewed:
2. Name of subscriber, if different than "1" above:
3. Name of plan:
4. Subscriber or Enrollee Account or Identification Number:
5. If applicable, the Group Identification Number:
6. Date notice of cancellation or refusal to renew was received:
7. Attach copies of:
   (a) The notice of cancellation or refusal to renew received from the plan.
   (b) Any correspondence with the plan regarding such cancellation or refusal to renew.
8. State why such cancellation or refusal to renew is believed to be an improper action by the plan:
9. Are you aware of the existence of any grounds for cancellation or refusal to renew under the terms of the agreement with the plan?

10. Explain why you believe that the cause or causes for cancellation enumerated in the notice of cancellation received from the Plan are inadequate or untrue. Attach copies of any documents which are relevant to your explanation.
11. Does such cancellation or refusal to renew prevent or interfere with providing medical care to any person currently in need of such care?
12. Has the person named in item 1 above whose benefits were canceled received any medical or health care since the cancellation? If so, what services have been received and how much did they cost?

_____
Signature of Complainant

(b) Upon receipt of a complaint pursuant to subsection (b) of Section 1365 of the Act, the Commissioner will immediately forward a copy of such complaint to the plan, together with a request that the plan furnish the Commissioner with

(1) a copy of the notice of cancellation or refusal to renew,

(2) a copy of any correspondence relating thereto,

(3) a statement of the reason for such cancellation or refusal to renew and

(4) a response to the complainant's allegations pursuant to Item 9 of the complaint form in subsection (a). Such information shall be returned to the Commissioner by the plan within 10 business days following its receipt of the Commissioner's request.

(c) Following examination of the information provided pursuant to subsection (a) and (b), the Commissioner will notify the complainant and the plan of the determination of whether or not a proper complaint exists under the provisions of subdivision (b) of Section 1365 of the Act.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.

HISTORY:

1. Amendment of subsection (a) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.66. Deceptive Plan Names.

(a) A change of plan name is a "material modification" of the plan within the meaning of subdivision (b) of Section 1352 of the Act.

(b) A plan name will be considered deceptive if it suggests the quality of care furnished by the plan, or that full benefits are provided for health care or a specialized area of health care, or that the cost of benefits to members of the plan is lower than the cost of similar benefits purchased elsewhere, and in any such case the express or implied representation contained in the plan name is demonstrably untrue or is not supported by substantial evidence, at all times while such name is used by the plan. Nothing in this subsection limits or restricts the Commissioner from a determination that a plan or solicitor firm name is deceptive for reasons other than those stated herein.

Article 7. Standards

1300.67. Scope of Basic Health Care Services.

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Commissioner may approve:

(a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians.

(1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(b) Inpatient hospital services, which shall mean short-term general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization.

(c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(d) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography.

(e) Home health services, which shall include, where medically appropriate, health services provided at the home of an enrollee as prescribed or directed by a physician or osteopath licensed to practice in California. Such home health services shall include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide.

(1) Home health services may also include such rehabilitation, physical, occupational or other therapy, as the physician shall determine to be medically appropriate.

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,
(1) reasonable health appraisal examinations on a periodic basis;
(2) a variety of voluntary family planning services;
(3) prenatal care;
(4) vision and hearing testing for persons through age 16;
(5) immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service;
(6) venereal disease tests;
(7) cytology examinations on a reasonable periodic basis;
(8) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

(g) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan. Coverage for out-of-area emergencies involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.67.1. Continuity of Care.

Within each service area of a plan, basic health care services shall be provided in a manner which provides continuity of care, including but not limited to:

(a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;

(b) The encouragement of each enrollee to select a primary physician;

(c) The maintenance and ready availability of medical records, with sharing within the plan of all pertinent information relating to the health care of each enrollee;

(d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;

(e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.67.2. Accessibility of Services.

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

(g) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

1300.67.3. Standards for Plan Organization.

(a) The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include:

(1) separation of medical services from fiscal and administrative management sufficient to assure the Commissioner that medical decisions will not be unduly influenced by fiscal and administrative management,

(2) staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business, and

(3) written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.67.4. Subscriber and Group Contracts.

(a) All subscriber and group contracts and endorsements and amendments shall be printed legibly in not less than 8-point type and shall include at least the following:

(1) The information required to be included on disclosure forms by Section 1363(a) of the Code and

(A) the information required to be included on disclosure forms by Section 1300.63 (except subsections (2), (3), (4) and (11) of subsection (b) thereof), and required to be included on evidences of coverage by subsections (b)(2) and (c) (except subsection (16) thereof) of Section 1300.63.1, or

(B) if the plan complies with the provisions of Section 1300.63.2, the information required to be included on combined evidences of coverage and disclosure forms by Section 1300.63.2 (except subsections (1) and (4) of subsection (b) and subsections (2), (25), and (27) of subsection (c) thereof).

(2) Definitions of all terms contained in the contract.

(A) Which are defined by the Act or Subchapter 5.5 of Chapter 3 of Title 10 of the California Administrative Code,

(B) Which are any of the following: "pre-existing condition", "guaranteed renewable", or "non-cancellable", or,

(C) Which require definition in order to be understood by a reasonable person not possessing special knowledge of law, medicine, or plans;

(D) Which specifically describes the eligibility of persons as subscribers or enrollees.

(3) Appropriate captions, in boldface type, for the following provisions: limitations, exclusions, exceptions, reductions, deductibles, copayments and other provisions which may decrease or limit benefits to, or increase costs of, any subscriber or enrollee;

(A) A benefit afforded by the contract shall not be subject to any limitation, exclusion, exception, reduction, deductible, or copayment which renders the benefit illusory.

(4) In the same section describing any particular benefit(s), any provisions described in (3) above which are applicable only to any such particular benefit(s);

(5) Provisions relating to cancellation under an appropriate caption, in boldface type, which provisions shall include:

(A) A statement of the bases for cancellation, which shall conform to Section 1365(a) of the Act and these rules;

(B) A statement of the opportunity for review of certain cancellations by the Commissioner as provided in Section 1365(b) of the Code;

(C) A statement that, in the event of cancellation by either the plan (except in the case of fraud or deception in the use of services or facilities of the plan or knowingly permitting such fraud or deception by another) or the other party, the plan shall within 30 days return to the other part the pro rata portion of the money paid to plan which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due the plan;

(D) A statement of the time when a notice of cancellation becomes effective;

(E) A statement that receipt by the plan of the proper prepaid or periodic payment after cancellation of the contract for nonpayment shall reinstate the contract as though it had never been cancelled if such payment is received on or before the due date of the succeeding prepaid or periodic payment, provided, however, that the contract may specify one or more of the following methods by which the plan may avoid such reinstatement:

1. In the notice of cancellation, the plan notifies the other party that if payment is not received within 15 days of issuance of the notice of cancellation, a new application is required and the conditions under which a new contract will be issued or the original contract reinstated; or

2. If such payment is received more than 15 days after issuance of the notice of cancellation, the plan refunds such payment within 20 business days; or

3. If such payment is received more than 15 days after issuance of the notice of cancellation, the plan issues to the other party, within 20 business days of receipt of such payment, a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the cancelled contract in benefits, coverage or otherwise;

(6) A provision prohibiting the plan from increasing the amount paid by the other party, except after a period of at least 30 days from and after either the postage paid mailing to the other party at the other party's address of record with the plan or actual hand delivery to the other party of written notice of such proposed increase;

(7) A provision prohibiting the plan from decreasing in any manner the benefits stated in the contract, except after a period of at least 30 days from and after either the postage paid mailing to the other party at the other party's address of record with the plan or actual hand delivery to the other party of written notice of such proposed change;

(8) A provision requiring the plan to provide written notice within a reasonable time to the other party of any termination or breach of contract by, or inability to perform of, any contracting provider if the other party may be materially and adversely affected thereby;

(9) A provision that (i) the plan is subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Subchapter 5.5 of Chapter 3 of Title 10 of the California Administrative Code, and (ii) any provision required to be in the contract by either of the above shall bind the plan whether or not provided in the contract.

(10) A provision that, upon termination of a provider contract, the plan shall be liable for covered services rendered by such provider (other than for copayments as defined in subdivision (g) of Section 1345) to a subscriber or enrollee who retains eligibility under the applicable plan contract or by operation of law under the care of such provider at the time of such termination until the services being rendered to the subscriber or enrollee by such provider are completed, unless the plan makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

(11) In the case of a group contract, a reasonable provision requiring the group contract holder to mail promptly to each subscriber a legible, true copy of any notice of cancellation of the plan contract which may be received from the plan and to provide promptly to the plan proof of such mailing and the date thereof, if the plan wishes to obligate the group contract holder in connection with the obligations imposed on the plan by Section 1300.65.

(b) For the purposes of this section:

(1) "Other party" means (i) in the case of a group contract, the group representative designated in the contract, and (ii) in the case of an individual contract, the subscriber.

(2) Any express or implied requirement of notice to the other party, in the context of a group contact, requires notice to the group representative designated in the contract and, with respect to material matters, to subscribers and enrollees under the group contract; however, a plan may fulfill any obligation imposed by this section to notify subscribers and enrollees under a group contract if it provides notice to the group representative designated in the contract, and the group contract requires the group representative to disseminate such notice to subscribers and enrollees in the group by the next regular communication to the group but in no event later than 30 days after the receipt thereof.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367 and 1379, Health and Safety Code.

HISTORY:

1. New subsection (a) (10) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (a) (5) filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
3. Amendment of subsection (a) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.67.8. Contracts with Providers.

Written contracts must be executed between the plan and each provider of health care services which regularly furnishes services under the plan. All contracts with providers shall be subject to the following requirements:

(a) A written contract shall be prepared or arranged in a manner which permits confidential treatment by the Commissioner of payment rendered or to be rendered to the provider without concealment or misunderstanding of other terms and provisions of the contract.

(b) The contract shall require that the provider maintain such records and provide such information to the plan or to the Commissioner as may be necessary for compliance by the plan with the provisions of the Act and the rules thereunder, that such records will be retained by the provider for at least two years, and that such obligation is not terminated upon a termination of the agreement, whether by rescission or otherwise. (See Section 1300.75.1)

(c) That the plan shall have access at reasonable times upon demand to the books, records and papers of the provider relating to the health care services provided to subscribers and enrollees, to the cost thereof, to payments received by the provider from subscribers and enrollees of the plan (or from others on their behalf), and, unless the provider is compensated on a fee-for-service basis, to the financial condition of the provider.

(d) The contract shall prohibit surcharges for covered services and shall provide that whenever the plan receives notice of any such surcharge it shall take appropriate action.

(e) The contract shall contain provisions complying with Section 1379 of the Act and requiring that, upon termination of the contract of the provider for any cause, such provider shall comply with the provisions of subdivision (a) (10) of Section 1300.67.4.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1367, 1381 and 1385, Health and Safety Code.

HISTORY:

1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (b) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.67.10. Discrimination Prohibited.

(a) No health care service plan or specialized health care service plan shall refuse to enter any contract or shall cancel or decline to renew or reinstate any contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a subscriber, enrollee, member or otherwise.

(b) The terms of any contract shall not be modified and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, co-insurance, deductibles, reservations, or premium, price or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from any such contract as a subscriber, enrollee, member or otherwise; except that premium, price or charge differentials because of the sex or age of any such individual and based on objective, valid, and up-to-date statistical and actuarial data are not prohibited.

1300.67.11. Disclosure of Conflicts of Interest.

(a) A plan shall not enter into any transaction with a person currently named in its application under Section 1300.51 pursuant to Items 7, 8 or 9 unless, prior thereto, each of the following conditions is met:

(1) The material facts concerning the transaction and the person's interest therein are disclosed to the governing body of the plan.

(2) The transaction is approved by a disinterested majority of the governing body.

(3) Such facts and such approval are made a part of the minutes of such governing body or, if no minutes are required of such governing body, otherwise retained as a record of the plan.

(b) A plan shall promptly give written notice to the Commissioner if a transaction is entered into otherwise than in conformity with the terms of this section.

(c) For the purposes of this section, "governing body" means the board of directors, all general partners, the sole proprietor, the board of trustees, and any other persons occupying a similar position or performing similar functions.

1300.67.12. Contracts with Solicitor Firms.

A plan shall not permit a solicitor firm to solicit enrollments or subscriptions on its behalf except pursuant to a written contract which meets all of the following minimum requirements:

(a) All funds received by the solicitor firm for the account of the plan shall at all times be segregated from the assets of the solicitor firm and shall be promptly deposited to a trust account in a state or federal bank authorized to do business in this state and insured by an appropriate federal insuring agency. "Promptly deposited" means deposited no later than the business day following receipt by the solicitor firm.

(b) All funds received by the solicitor firm for the account of the plan shall be transmitted to the plan, or to a person designated in the contract, net of actual commissions earned under the particular contract within (5) five business days after such funds are received by the solicitor firm.

(c) The solicitor firm shall comply and shall cause its principal persons and employees to comply with all applicable provisions of the Act and the rules thereunder.

(d) The solicitor firm shall promptly notify the plan of the institution of any disciplinary proceedings against it or against any of its principal persons or employees relating to any license issued to any such person by the California Insurance Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. Amendment filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.67.13. Coordination of Benefits.

(a) A plan may or may not coordinate benefits in some or all of its group and/or individual contracts. However, a plan which does coordinate benefits may do so only pursuant to provisions in its plan contracts, all of which provisions shall be fair, reasonable, and consistent with the objectives of the Act.

(b) A provision regarding coordination of benefits shall be presumed to be unfair and unreasonable if it may:

(1) Relieve the plan of a duty otherwise arising from a plan contract to deliver any health care service to any subscriber or enrollee in need thereof because such subscriber or enrollee may be or is entitled to coverage of any such service by any other health carrier;

(2) Result in any subscriber or enrollee who cooperates with such provision having greater personal liability for any particular health care service furnished by or through the plan or received in reliance on the plan than such person would have had in the absence of any other health carrier;

(3) Enrich any subscriber or enrollee beyond the amount, if any, of actual out-of-pocket expenses for any particular health care service furnished by or through the plan or received in reliance on the plan;

(4) Discriminate among subscribers or enrollees in the same or similar circumstances;

(5) Require any subscriber or enrollee to pay the plan for the cost of health care services furnished by or through the plan in the event that any other health carrier refuses to pay the plan, unless the subscriber or enrollee has failed to cooperate in a reasonable manner with the plan's efforts to secure payment from such other health carrier;

(6) Result in a delay in furnishing any reasonably necessary health care service pursuant to a plan contract to any subscriber or enrollee;

(7) Result in an unreasonable delay in reimbursing any subscriber or enrollee entitled to reimbursement from the plan for the cost of any particular health care service pursuant to the plan contract;

(8) Require the coordination of benefits provided under individual contracts or policies issued by any other health carrier; or

(9) Result in an exception or reduction of benefits from the plan if any subscriber or enrollee has entitlement to Medi-Cal benefits.

(c) The term "health carrier" is defined to include any health care service plan, nonprofit hospital service plan, insurer, employee benefit plan, fraternal benefit society, firemen's, policemen's or peace officers' benefit and relief association, and any other governmental or private program which provides or arranges for the provision of, or pays, reimburses, or indemnifies for the cost of, any health care services whether pursuant to statutory requirement or provision or otherwise.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

1300.67.50. Certain Medicare Supplement Contracts: Presumption of Unfairness.

(a) A plan contract which is a contract of a plan which is not a federally qualified health maintenance organization or other plan organized and operated exclusively as a health maintenance organization (staff model, group model, or individual practice association model) and which primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage on a reimbursement basis is subject to the provisions of this section.

(b) A contract described in subsection (a) shall be deemed not to be fair, just, or consistent with the objectives of the Act at all times, and shall not be advertised, solicited for, entered, or renewed at any time, except during that period of time, if any, beginning with the date of receipt by the plan of notification by the Commissioner that the provisions of such contract are deemed to be fair, just, and consistent with the objectives of the Act, and ending with the earlier to occur of the events indicated in subsection (c).

(c) The period of time indicated in subsection (b) shall terminate at the earlier to occur of (1) receipt by the plan of written revocation by the Commissioner of the immediate past notification referred to in subsection (b) specifying the basis for such revocation, (2) the last day of the prepaid or periodic charge calculation period, or (3) the 30th day of June of the next succeeding calendar year.

(d) A plan described in subsection (a) shall secure the Commissioner's review of a plan contract subject to the provisions of subsection (a) by submitting, not less than 30 days prior to any proposed advertising or other use of the plan contract not already protected by a currently effective notice under subsection (b), the following for the Commissioner's review:

(1) a copy of the plan contract;

(2) a copy of the disclosure form (or combined evidence of coverage and disclosure form);

(3) a representation that the plan contract complies with the provisions of the Act and these rules;

(4) a copy of the calculations for the expected loss ratio;

(5) supporting data used in calculating the expected loss ratio as indicated in Section 1300.67.53 of these rules;

(6) an actuarial certification, as specified in Section 1300.67.53 of these rules, of the loss ratio computations;

(7) if required by the Commissioner, actuarial certification, as specified in Section 1300.67.53 of these rules, of the loss ratio computations by one or more unaffiliated actuaries acceptable to the Commissioner;

(8) an undertaking by the plan to notify the subscribers in writing within 60 days of decertification, if the contract is identified as a certified contract at the time of sale and later decertified;

(9) a signed statement of the president of the plan or other officer of the plan designated by such person attesting that the information submitted for review is accurate and complete and does not misrepresent any material fact.

(e) A plan described in subsection (a) which submits information pursuant to subsection (d) shall provide such additional information as may be requested by the Commissioner to enable the Commissioner to conclude that the plan contract complies with the provisions of the Act and these rules.

(f) For the purposes of this section, the term "certified", as applied to a plan contract, means that the Commissioner by written notice has found that such contract complies with the provisions of the Act and these rules and, if authorized by the federal Department of Health and Human Services to authorize complying plans to display the emblem referred to below, has authorized the plan to display on the plan contract the particular emblem approved by the federal Department of Health and Human Services and indicating that such contract meets the certification requirements of 42 U.S.C. 1395ss and the regulations of the Health Care Financing Administration thereunder, and has not by written notice revoked such notice.

(g) For the purposes of this section, the term "decertified", as applied to a plan contract, means that the Commissioner by written notice has found that such contract no longer complies with the provisions of the Act and these rules and has revoked the prior authorization to display on the plan contract the emblem indicating certification.

(h) Notwithstanding the provisions of the section, this section shall not apply to any group contract which is:

(1) A group contract with one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations, or

(2) A group contract with any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of such contract to its members.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.67.51. Medicare Supplement Contract Provisions.

(a) No plan which is not a federally qualified health maintenance organization may advertise, solicit for, enter or renew any plan contract which primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage if such contract contains any of the prohibited provisions described in subsection (b), does not contain any of the mandatory provisions described in subsection (c), or does not conform to the requirements set forth in subsection (d).

(b) The following provisions shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of the Act and shall not be contained in any plan contract subject to subsection (a):

(1) Any waiver, exclusion, limitation or reduction based on or relating to a preexisting disease or physical condition, unless any such waiver, exclusion, limitation or reduction (A) applies only to coverage for specified services rendered not more than 6 months from the effective date of coverage, (B) is based on or relates only to a preexisting disease or physical condition defined no more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage, (C) does not apply to any coverage under any group contract, and (D) is approved in advance by the Commissioner.

(2) Any provision delaying the effective date of coverage beyond the first day of the month following the date of receipt by the plan of the applicant's properly completed application, except that the effective date of coverage may be delayed until the 65th birthday of an applicant who is to become eligible for Medicare by reason of age if the application is received any time during the three months immediately preceding the applicant's 65th birthday.

(3) Any distinction in coverage based on whether health care services are provided because of illness or injury.

(4) Any provision covering a health care service not covered by Medicare, unless the contract provides at least 50 percent of the reasonable charges for, or value of, each such health care service.

(5) The terms "Medicare supplement", "medigap", and terms of similar import to characterize a plan contract, unless such contract is in compliance with the provisions of the Act and these rules.

(6) If the plan contract purports to be "non-cancellable", "guaranteed renewable", or "non-cancellable and guaranteed renewable", any provision allowing cancellation or nonrenewal by the plan for any reason other than those specified in Section 1365(a)(1) and (2) of the Act, including, for the purpose of this subsection, any false representations to, or concealment of material facts from, the plan in any health statement, application, or written instruction furnished by the subscriber to the plan either before or after the effective date of the contract.

(7) Any provision allowing termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the subscriber, other than the nonpayment of the prepaid or periodic charge.

(8) Except with respect to a group contract subject to and in compliance with Section 1399.62 of the Act, any provision denying coverage, after termination of the contract, for services provided continuously beginning while the contract was in effect, during the continuous total disability of the subscriber or enrollee, except that such coverage may be limited to a reasonable period of time not less than the duration of the contract benefit period, if any, and may be limited to the maximum benefits provided under the contract.

(9) Any definition, condition, limitation, exclusion, reduction, or other provision which is inconsistent with or more restrictive or limiting than such term as officially used in Medicare, except as expressly authorized in the Act or these rules, provided, however, that sub-items (A), (D), (I) and (J) of item (10) of this subsection shall not be construed as such express authorization with respect to any plan which is not organized and operated exclusively as a health maintenance organization (staff model, group practice model, or individual practice association model).

(10) Any limitation or exclusion related to or based on type of illness, accident, treatment, or medical condition, except the following and any lesser and included limitation or exclusion not otherwise impermissible:

(A) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(B) mental or emotional disorders, alcoholism and drug addiction;

(C) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

(D) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

(E) services performed in a hospital by house officers, residents, interns or others in training;

(F) services performed by a member (by blood, marriage, or adoption) of the covered person's immediate family, or by one who ordinarily resides in the subscriber's home, and services for which no charge is normally made in the absence of insurance;

(G) dental care or treatment, dental surgery, and dental appliances;

(H) eye glasses, hearing aids, and examination for the prescription or fitting thereof;

(I) rest cures, custodial care, transportation;

(J) territorial limitations consistent with the plan's service area previously approved by the Commissioner;

(K) services incident to hospitalization or confinement in a health facility primarily for custodial, maintenance, or domiciliary care, or rest; or to control or change a patient's environment;

(L) services for or incident to vocational, educational, recreational, art, dance or music therapy; and, unless (and then only to the extent) medically necessary as an adjunct to medical treatment of an underlying medical condition and prescribed by the attending plan physician, and recognized by Medicare, weight control programs or exercise programs;

(M) services for or incident to intersex surgery (transsexual operations) or any resulting medical complications;

(N) blood plasma, except that this exclusion shall not apply to the first three (3) pints of blood received in a benefit period;

(O) acupuncture;

(P) services not covered by Medicare, unless specifically listed as plan benefits;

(Q) services which are not reasonably necessary in the exercise of good medical practice for diagnosis and treatment of an illness or injury or for a covered periodic health appraisal examination. (Examples of services which are not medically necessary may include hospitalization for diagnostic studies which could have been provided on an outpatient basis, hospitalization primarily for observation or evaluation, and hospitalization to control or change the patient's environment.)

(R) benefits provided under Medicare, pursuant to Title XVIII of the Social Security Act, as amended. This exclusion applies to all persons eligible to enroll under, or otherwise entitled to receive benefits from, Medicare, from the date of such eligibility or entitlement, including persons who do not enroll or otherwise apply for Medicare benefits, from the date entitlement to such benefits could have been effected; provided, however, that this exclusion does not relieve the health care service plan from any contractual obligation it may have to deliver services directly to the subscriber or enrollee;

(S) benefits to which the subscriber or enrollee is entitled under any state or federal workers' compensation, or employer's liability or occupational disease law, or any motor vehicle no-fault law; provided, however, that the health care service plan's rights under this provision will be limited to the establishment of a lien upon such other benefits;

(T) any benefits, including room and board, provided by any governmental hospital, institution, or agency (federal, state, county, municipality, or other political subdivision), except that this exclusion shall not apply to benefits provided under Medi-Cal or Medicaid;

(U) benefits provided under any other health care service plan contract, health maintenance organization contract, or medical or hospital service contract.

(c) A plan contract subject to subsection (a) shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of the Act and shall not be advertised, solicited for, entered, or renewed unless it contains the following mandatory provisions:

(1) Prominently printed on the first page of the contract, a notice stating in substance that the subscriber or enrollee shall have the right to return the contract within thirty (30) days of its delivery and to have the prepaid or periodic charge refunded if, after examination of the contract, the covered person is not satisfied for any reason.

(2) Appropriately captioned, and appearing on the first page of the contract, a provision regarding renewal, continuation or nonrenewal. Such provision shall clearly state the duration, where limited, of renewability, and the duration of the term for which the contract is issued and for which it may be renewed, and shall be consistent with Section 1365(a) of the Act and these rules.

(3) Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any charges in the applicable Medicare deductible amount and copayment percentage factors and the amount of prepaid charges may be modified, as indicated in Section 1300.67.4(a)(6) of these rules, to correspond with such changes.

(4) The health care service plan shall not in any way reduce or eliminate any benefit or coverage under a Medicare supplement contract at any time after the date of entering such contract (including dates of reinstatement or renewal) unless and until such change is voluntarily agreed to in writing signed by the subscriber or enrollee. The health care service plan shall not increase benefits or coverage with a concomitant increase in prepaid or periodic charges during the term of the contract unless and until such change is voluntarily agreed to in writing signed by the subscriber or enrollee or unless the increased benefits or coverage is required by law or regulation.

(5) If plan contract provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import, a definition of such terms.

(6) The provisions required to be set forth in the plan contract by Section 1300.67.4 of these rules.

(d) A plan contract subject to subsection (a) shall be deemed to be unfair, unreasonable and inconsistent with the objectives of the Act and shall not be advertised, solicited for, entered, or renewed unless such contract contains definitions of terms in compliance with the following requirements:

(1) "Accident", "Accidental Injury", or "Accidental Means", if defined, shall be defined without including words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided, means accidental bodily injury sustained by the covered person."

(2) "Benefit Period" or "Medicare Benefit Period" shall not be defined as more restrictively than as defined in the Medicare program.

(3) "Convalescent Nursing Home", "Extended Care Facility", or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services. A definition of such home or facility shall not be more restrictive than one requiring that it be operated pursuant to law; be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested; be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; provide continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and maintains a daily medical record of each patient; provided, however, that such definition may provide that such term shall not be inclusive of any home, facility or part thereof used primarily for rest; a home or facility for the aged or for the care of drug addicts or alcoholics; or a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(4) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital be an institution operating pursuant to law; be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s); provided, however, that such definition may state that such term shall not be inclusive of convalescent homes, convalescent, rest, or nursing facilities; facilities primarily affording custodial, educational or rehabilitory care; facilities for the aged, drug addicts or alcoholics; or any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(5) "Medicare" shall be defined in the contract. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act", "as then constituted and any later amendments or substitutes thereof", or words of similar import.

(6) "Medicare Eligible Expenses" shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by plans for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(7) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or personality disorder.

(8) "Nurse" may be defined so as to restrict the term to a stated type of nurse, such as registered graduate professional nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.). If the term "nurse", "trained nurse", or "registered nurse" is used without specific definition, the plan shall recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative regulations of the licensing or registry board of the state.

(9) "Physician" may be defined by use of such terms as "duly qualified physician" or "duly licensed physician". A plan using either such term shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment to the extent that such services are within the scope of the provider's license and are provided pursuant to applicable laws.

(10) "Sickness", if defined, shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of a covered person."

(e) Nothing in this section shall be construed as prohibiting any plan contract, by definitions or express provisions, from limiting or restricting any or all of the benefits provided under the contract (except in-area and out-of-area emergency services) to those health care services which are delivered by plan employed, owned, or contracting providers and provider facilities, so long as such plan contract complies with the provisions of Section 1367 of the Act and Sections 1300.67 and 1300.67.52 of these rules.

(f) Nothing in this section shall be construed as prohibiting any plan contract which limits or restricts any or all of the benefits provided under the contract in the manner contemplated in subsection (e) from limiting its obligation to deliver services, and disclaiming any liability from any delay or failure to provide such services, (1) in the event of a major disaster or epidemic or (2) in the event of circumstances not reasonably within the control of the plan, such as the partial or total destruction of facilities, war, riot, civil insurrection, disability of a significant part of its health personnel, or similar circumstances so long as such provisions comply with the provisions of Section 1367(h) of the Act.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.67.52. Medicare Supplement Additional Benefit Requirements.

No plan which is not a federally qualified health maintenance organization may advertise, solicit for, or enter any plan contract which primarily or solely supplements Medicare, or advertise or represent any plan contract as a supplement to Medicare, unless such contract complies with the provisions of the Act and these rules and provides at least all of the following minimum benefits:

(a) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through 90th day in any Medicare benefit period;

(b) coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(c) upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(d) coverage of Part A Medicare eligible expenses for skilled nursing facility care to the extent not covered by Medicare;

(e) coverage of 20 percent of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

NOTE: Authority cited: Sections 1344, 1367 and 1367.15, Health and Safety Code. Reference: Sections 1344, 1367 and 1367.15, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

1300.67.53. Medicare Supplement Minimum Aggregate Benefits.

(a) No plan which is not a federally qualified health maintenance organization or other plan organized and operated exclusively as a health maintenance organization (staff model, group practice model, or individual practice association model) may advertise, solicit for, enter, or renew any plan contract which primarily or solely supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage on a reimbursement basis unless such contract returns to the subscribers and enrollees in the form of aggregate benefits under the contract, as estimated for the entire period for which prepaid or periodic charges are computed to provide coverage, on the basis of incurred claims experience and earned prepaid or periodic charges for such period and in accordance with accepted actuarial principles and practices:

(1) At least 75 percent of the aggregate amount of prepaid or periodic charges collected in the case of group contracts, and

(2) At least 60 percent of the aggregate amount of prepaid or periodic charges collected in the case of individual contracts.

(b) For the purposes of this section, Medicare supplement contracts entered as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be deemed to be individual contracts.

(c) The calculation of expected loss ratios shall be pursuant to such formula, definitions, procedures, and other provisions as may be deemed by the Commissioner, with due consideration of the circumstances of the particular plan, to be fair, reasonable, and consistent with the objectives of the Act.

(d) Each plan subject to subsection (a) shall submit to the Department a copy of the calculations for the expected loss ratio as required by Section 1300.67.50 of these rules. Such calculations shall include the following data: the scale of prepaid or periodic charges for the loss ratio calculation period, a description of all assumptions, the formula used to calculate gross prepaid or periodic charges, the expected level of earned prepaid or periodic charges in the loss ratio calculation period, and the expected level of incurred claims for reimbursement (including paid claims and incurred but not paid claims) in the loss ratio calculation period. Such calculations shall be accompanied by an actuarial certification, consisting of a signed declaration of an actuary who is a member in good standing of the American Academy of Actuaries in which such actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account actual plan contract experience, if any, and reasonable expectations, and that the calculations are in accordance with the provisions of subsection (c) and the provisions referred to therein. In addition, the Commissioner may require the plan to submit actuarial certification, as described above, by one or more unaffiliated actuaries acceptable to the Commissioner.

(e) Notwithstanding the provisions of this section, this section shall not apply to any group contract which is:

(1) A group contract with one or more employers or labor organizations, or trustees of a fund established by one or more employers or organizations, or combination thereof, for employees or former employees or combination thereof or for members or former members, or combination thereof, of the labor organizations, or

(2) a group contract with any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association is composed of individuals all of whom are actively engaged in the same profession, trade or occupation, has been maintained in good faith for purposes other than obtaining health coverage, and has been in existence for at least two years prior to the date of its initial offering of such contract to its members.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).

Article 8. Self-Policing Procedures

1300.68. Grievance System.

A plan grievance system established pursuant to the requirement of Section 1368 of the Act shall include at least the following features:

(a) The system shall be established, pursuant to written procedures, for the receipt, handling and disposition of complaints. An officer of the Plan shall be designated as having primary responsibility for the maintenance of such procedures and for the review of their operations and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the Plan's administration.

(b) At least one telephone number for the filing of complaints shall be located within each service area including major facilities of providers which are extensively used by the Plan. The locations and telephone numbers and related procedures regarding grievances shall be communicated in writing to enrollees and subscribers. "Major facility" does not include offices of health professionals.

(c) As to each complaint received in person or by telephone at a grievance location, a written record shall be made, including the date, identification of the individual recording the grievance, and disposition. A written record of tabulated grievances shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to Section 1300.69, and by an officer of the Plan or his designate, and the review procedure shall be documented, including documentation of the procedure or mechanism used in consideration of tabulating grievances periodically in relation to policy and procedure review.

(d) At each grievance location, assistance shall be provided in the filing of grievances. A "patient advocate" or ombudsperson may be used.

(e) Complaint forms and a copy of the grievance procedure shall be readily available at each facility of the plan, including facilities of providers, which furnishes services to subscribers and enrollees and shall be furnished promptly upon receipt of a request therefor by mail or telephone.

(f) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

(g) A grievance system shall provide (1) for the acknowledgement of the receipt of a complaint and notice to the complainant of who may be contacted with respect thereto within 20 days, and (2) for notice to the complainant of the disposition of the complaint, normally within 30 days. Where a plan is unable to distinguish between complaints and inquiries, they shall be considered complaints.

(h) A grievance system shall provide for a prompt review of complaints by the management or supervisory staff responsible for the services or operations which are the subject of the complaint.

1300.69. Public Policy Participation by Subscribers.

Unless a plan complies with the requirements of the Health Maintenance Organization Act of 1973 in affording subscribers and enrollees procedures to participate in establishing the public policy of the plan, as defined in Section 1369 of the Act, it shall comply with each of the following requirements:

(a) If the plan is a corporation, either:

(1) At least one-third of its governing board shall be subscribers and/or enrollees, or

(2) There shall be established a standing committee which shall be responsible for participating in establishing public policy of the plan as defined in Section 1369 of the Act, and whose recommendations and reports are regularly and timely reported to the governing board. The governing board shall act upon such recommendations and such action shall be recorded in the board's minutes. The membership of the standing committee shall comply with each of the following:

(A) At least 51% of the members shall be subscribers and/or enrollees,

(B) At least one member shall be a member of the governing board of the plan, and

(C) At least one member shall be a provider.

(b) If the plan is a partnership, trust or unincorporated association, there shall be established a standing committee of the governing body or executive committee of the plan, which committee shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations and reports are regularly and timely reported to the governing body or executive committee of the plan. The governing body or executive committee of the plan shall act upon such recommendations and such action shall be recorded in its minutes. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) At least one member shall also be a member of the governing body or executive committee of the plan, and

(3) At least one member shall be a provider.

(c) If the plan is a sole proprietorship, it shall establish a standing committee which shall be responsible for participation in establishing public policy of the plan as defined in Section 1369 of the Act and whose recommendations are reported regularly and timely to the sole proprietor. The sole proprietor shall act upon such recommendations and such action shall be recorded. The membership of the standing committee shall comply with each of the following:

(1) At least 51% of the members shall be subscribers and/or enrollees,

(2) The sole proprietor shall be a member, and

(3) At least one provider shall be a member.

(d) Those individuals who fulfill the requirements stated in this section for subscriber and/or enrollee membership upon the governing body or standing committee shall be persons who are not employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan.

(e) Advisory committees do not meet the requirements of subsections (a), (b) or (c).

(f) Enrollees and subscribers participating in establishing public policy shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition.

(g) In connection with the selection of enrollee and subscriber members of any governing board or standing committee, the plan shall generally consider the makeup of its enrollee and subscriber population, including but not limited to factors such as ethnic extraction, demography, occupation and geography as well as identifiable and individual group participation. Any such selection or election of enrollee or subscriber members shall be conducted on a fair and reasonable basis. This subsection does not require the plan to maintain supporting statistical data.

(h) The public policy participation procedure shall be incorporated into the bylaws or other governing documents of the plan. The terms of subscriber and enrollee members of the public policy making body shall be of reasonable length and overlap so as to provide continuity and experience in representation. A standing committee shall meet at least quarterly.

(i) The plan shall (1) in each evidence of coverage or combined evidence of coverage and disclosure form, or at least annually by other means, furnish to its subscribers and enrollees a description of its system for their participation in establishing public policy, and (2) communicate material changes affecting public policy to subscribers and enrollees.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1369, Health and Safety Code.

HISTORY:

1. Amendment of subsection (i) filed 1-12-83, effective thirtieth day thereafter (Register 83, No. 3).

1300.70. Internal Quality of Care Review System.

(a) Each Plan shall design a reasonable, formal quality of care review system and shall implement the same effectively, efficiently and continuously, and shall demonstrate the reasonableness of the design and the adequacy of the implementation thereof to the Commissioner. The quality of care review system shall be designed and implemented so as to assure quality health care for the benefit of the Plan's enrollees. It shall have as its primary goal the systematic improvement of health care and shall be concerned with structure, processes, and outcomes they interrelate.

(b) The following procedures are guidelines for the design of a quality of care review system. They are not intended to discourage the development of systems which otherwise substantially fulfill the requirements of Subsection (a). However, a system which includes the following procedures shall be presumptively reasonable:

(1) Identification of less than satisfactory performance of elements of care, by considering information from all reasonably available sources, including, for example, peer review, medical records audits, enrollee assessments audits, grievances and statistical reports.

(2) Establishment of valid, medically achievable standards by health professional peers for those identified elements of care which are amenable to standard setting and compliance measurement.

(3) Assurance that those standards which are established will be related to conditions which can be affected by medical intervention, apply to a significant number of patients, and apply to all parts of the provider system, rather than just one class of providers.

(4) Ratification, consensus and documented communication of these topics, objectives and criteria to all concerned.

(5) Objective measurement of actual performance as reflected in data gathered from medical records, enrollee assessments, and other sources so as to include a representative sample of all such performance, in order to determine apparent noncompliance with standards.

(6) Analysis by health professional peers of the results of objective measurement.

(7) Implementation of necessary corrective action, either immediate or routine, together with documentation thereof, and reports for additional medical, educational or administrative action as appropriate.

(8) Reaudit of actual performance after a specific scheduled interval to determine effectiveness of the remedial action, evaluation of the particular audit study documented, including problems identified, action taken, and results.

(9) Periodic documented critical review of the design and ongoing implementation and effectiveness of the quality of care review system by the health professional peers and the Plan's governing body.

(c) The health professionals of a Plan shall have the primary responsibility for the design and ongoing implementation of the quality of care review system. This responsibility ordinarily shall be discharged by committees of health professionals who provide services for the Plan, but nothing contained in this section shall relieve the Plan or its governing body from the ultimate management responsibility for the requirements hereunder imposed.

(d) In addition to the internal quality of care review system, a Plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and costs. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Commissioner.

1300.71. Plan Annual Statistical Report.

NOTE. Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1979, Ch. 1083.

HISTORY.

1. Repealer filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

Article 9. Financial Responsibility

1300.75. Agreements with Subsequent Providers.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

HISTORY:

1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

1300.75.1. Fiscal Soundness, Insurance, and Other Arrangements.

(a) A plan shall demonstrate fiscal soundness and assumption of full financial risk as follows:

(1) Demonstrate through its history of operations and through projections (which shall be supported by a statement as to the facts and assumptions upon which they are based) that the plan's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

(2) Demonstrate that its working capital is adequate, including provisions for contingencies.

(3) Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the contract period for which payment has been made, the continuation of benefits to subscribers and enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered.

(b) As a part of its program pursuant to subsection (a), a plan may obtain insurance or make other arrangements:

(1) For the cost of providing to any member covered health care services the aggregate value of which exceeds $5,000 in any year;

(2) For the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan; and

(3) For not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year.

(c) In passing upon a plan's showing pursuant to this section, the Commissioner will consider all relevant factors, including but not limited to:

(1) The method of compensating providers and the terms of provider contracts, especially as to the obligations of providers to subscribers and enrollees in the event of plan insolvency.

(2) The methods by which the plan controls and monitors the utilization of health care services.

(3) The administrative expenses (actual and projected) of the plan and especially as to new or expanding plans, the fiscal soundness of its program to acquire and service an expanded subscriber population.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1375.1, Health and Safety Code.

HISTORY:

1. Repealer and new section filed 9-27-79, effective thirtieth day thereafter (Register 79, No. 39).

2. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

1300.75.2. Plan as Subsequent Provider.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

HISTORY:

1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

1300.75.3. Subsequent Provider Exemption.

NOTE. Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

HISTORY:

1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

1300.76. Plan Tangible Net Equity Requirement.

(a) Each plan licensed pursuant to the provisions of the Act shall, at all times, have and maintain a tangible net equity at least equal to the following minimum amounts in relation to the number of enrollees entitled to health care services under contracts issued by the plan.

Number of Enrollees	*Amount of Tangible Net Equity*
5,000 or less	$10,000
5,001 to 7,000	15,000
7,001 to 9,000	20,000
9,001 to 11,000	25,000
11,001 to 20,000	30,000
20,001 to 40,000	40,000
40,001 to 60,000	50,000
60,001 to 80,000	60,000
80,001 to 100,000	70,000
100,001 to 120,000	80,000
120,001 to 140,000	90,000
140,001 to 160,000	100,000
160,001 to 180,000	110,000
180,001 to 200,000	120,000
200,001 to 300,000	170,000
300,001 to 400,000	220,000
400,001 to 500,000	270,000
500,001 to 600,000	320,000
600,001 and above	370,000

(b) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the Commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due; long term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least 110 percent of the amount owing.

(c) In making the computation of the "number of enrollees" for the purposes of subsection (a), a plan shall include that number of enrollees who are enrolled only under specialized health care service plan contracts which is that fraction of the actual number of such enrollees in which such plan's annual charges to subscribers and enrollees enrolled only under specialized health care service contracts is the numerator and the denominator is the average charges of health care service plan contracts (excluding specialized health care service plan contracts), as determined yearly by the Commissioner. "Charges", for the purposes of this subsection, include the periodic charges of the plan assessed against subscribers and enrollees or others on their behalf.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:

1. Amendment of subsections (b) and (c) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).

1300.76.2. Solicitor Firm Financial Requirement.

(a) Each solicitor firm which handles funds of plans, subscribers, or other persons contracting with plans, shall at all times maintain a tangible net worth at least equal to 20 percent of such firm's aggregate indebtedness or $10,000, whichever is greater, and shall maintain liquid net assets of at least $5,000 in excess of it current liabilities.

(b) A solicitor firm which accepts only funds in the form of checks payable to plans, subscribers or other persons contracting with plans and forwards such checks to the payee by the close of the business day following receipt thereof does not "handle funds" within the meaning of this section.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).

1300.76.3. Fidelity Bond.

(a) Each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner, and it shall provide for 30 days' notice to the Commissioner prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan determined by the following schedule:

Annual Gross Income			*Minimum Coverage*
Up to $100,000			$10,000
100,000	to	$300,000	20,000
300,000	to	500,000	30,000
500,000	to	750,000	50,000
750,000	to	1,000,000	75,000
1,000,000	to	2,000,000	100,000
2,000,000	to	4,000,000	200,000
4,000,000	to	6,000,000	400,000
6,000,000	to	10,000,000	600,000
10,000,000	to	20,000,000	1,000,000
20,000,000	and over		2,000,000

(b) The fidelity bond required pursuant to subsection (a) may contain a provision for a deductible amount from any loss which, except for such deductible provision, would be recoverable from the insurer. A deductible provision shall not be in excess of 10 percent of the required minimum bond coverage, but in no event shall the deductible amount be in excess of $100,000.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).

1300.76.4. Prohibited Financial Practices.

(a) No solicitor shall maintain, and no plan or solicitor firm shall permit a solicitor in its employ to maintain, an account with a financial institution for funds of the plan, solicitor firm, subscribers or group representatives, except an account which is in the name of and under the control of the plan or solicitor firm.

(b) No solicitor shall receive funds on behalf of a plan or solicitor firm, and no plan or solicitor firm shall permit a solicitor in its employ to receive funds on behalf of the plan or solicitor firm, but this section shall not prohibit a solicitor from receiving only funds in the form of checks payable to the plan or solicitor firm if such solicitor deposits such checks to an account of the plan or solicitor firm by the close of the business day following receipt thereof or forwards such checks to the plan or solicitor firm by the close of the business day following receipt thereof.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:

1. New section filed 11-9-77 as an emergency; effective upon filing (Register 77, No. 46).
2. Certificate of Compliance filed 2-6-78 (Register 78, No. 6).
3. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
4. Amendment of NOTE filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.77. Reimbursements.

(a) "Adequate insurance" for reimbursement for the purposes of subdivision (a) of Section 1377 means a performance bond or insurance policy issued by an insurer licensed by the California Insurance Commissioner, in an amount equal to at least the aggregate sum of the last four months of reimbursable payments for services of noncontracting providers which were made and accrued by the plan obtaining such insurance to providers of service and its subscribers and enrollees. The bond or insurance policy shall be payable to a corporate trustee for the benefit of noncontracting providers, subscribers and enrollees whose claims are unpaid upon the plan ceasing to do business because of insolvency or upon the plan being adjudged bankrupt.

(b) For the purposes of subdivision (a) of Section 1377 of the Act, "equivalents" to cash include only the following, provided that the investment in any one issuer of securities (other than securities issued or fully guaranteed or insured by the United States Government or any agency thereof) does not exceed 5% of the amount required pursuant to such subdivision:

(1) Shares listed on the New York Stock Exchange, the American Stock Exchange, the Pacific Stock Exchange or the O.T.C. Margin List, which shall be valued at 90 percent of their market value.

(2) Securities issued or guaranteed by the United States Government or any agency thereof, which shall be valued at the percentages of their market value specified below:

(A) less than 3 years to maturity—100%
(B) 3 or more years to maturity—98%.

(3) Obligations of any state or political subdivision or instrumentality thereof which are rated A or better by Moody's Investors Service or A or better by Standard & Poor's, which shall be valued at the percentages of their market value specified below:

(A) less than 5 years to maturity—98%
(B) 5 or more years to maturity—95%.

(4) Certificates of deposit or other evidence of deposit in, or acceptance of, a bank insured by the F.D.I.C. or certificates of deposit or share accounts of a savings and loan association insured by the F.S.L.I.C., which shall be valued at their book value.

(5) Promissory notes or other evidences of indebtedness having a maturity date within nine months of issuance, exclusive of days of grace, or any renewal thereof which is likewise limited, and which are rated P2 or better by Moody's Investors Service and A2 or better by Standard & Poor's, which shall be valued at their market value.

(6) Nonconvertible debt securities having a fixed maturity which are rated A or better by Moody's Investors Service or A or better by Standard & Poor's, which shall be valued at the percentages of their market value specified below:

(A) less than 2 years to maturity—100%
(B) 2 years but less than 5 years to maturity—98%
(C) 5 or more years to maturity—95%.

(c) The Commissioner may waive the "haircut" requirements set forth in subsection (b) subject to the condition that the plan establish and maintain a securities valuation reserve fund consisting of cash or equivalents in an amount not less than 10 percent of the total amount of "cash and equivalents" required under Section 1377 which is not otherwise maintained in cash, or such other amount as the Commissioner may require.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1377, Health and Safety Code.

HISTORY:

1. Amendment of subsection (b) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. New subsection (c) filed 12-8-82, effective thirtieth day thereafter (Register 82, No. 50).

1300.77.1. Estimated Liability for Reimbursements.

A plan subject to subdivision (b) of Section 1377 shall estimate its liability for incurred and unreported claims and record such estimate as an accrual in its books and records at least monthly.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

HISTORY:

1. Amendment filed 12-8-82, effective thirtieth day thereafter (Register 82, No. 50).

1300.77.2. Calculation of Estimated Liability for Reimbursements.

(a) Each plan subject to subdivision (b) of Section 1377 shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Commissioner. Such method may include a lag study as defined and illustrated in subsection (c), an actuarial estimate as defined in subsection (d), or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred and unreported claims.

(b) Working papers which support the incurred and unreported claims calculation shall be maintained as part of the records of the plan. Lag study working papers shall include a detailed allocation of all claims received each month to the various months in which the services were performed. Actuarial estimate working papers must detail all underlying assumptions and calculations in establishing the actuarial rate. Any other method used to determine the amount of incurred and unreported claims must be supported by adequate working papers, schedules or reports which detail all aspects of the incurred and unreported calculation.

(c) A "lag study" is a schedule which analyzes historical claims information on an ongoing basis to determine the length of time lag between the date of service and the date a claim is submitted to the plan for payment. Such a study distributes all claims received each month in which the services were performed. An example of a lag study containing the minimum information necessary to be held unobjectionable by the Commissioner is as follows:

ABC HEALTH PLAN OF CALIFORNIA
SCHEDULE TO CALCULATE HISTORIC PERCENTAGE OF INCURRED BUT UNREPORTED CLAIMS FOR PRIOR MONTHLY PERIODS WHICH HAVE BEEN FULLY OR SUBSTANTIALLY REPORTED
JULY 31, 19X2

	MONTH CLAIM RECEIVED							
	Same Month	*Second*	*Third*	*Fourth*	*Fifth*	*Sixth*	*Seventh*	*Totals for Months of Service*
Month of Service:								
Oct 19X1	$150	$500	$200	$100	$50			$1,000
Nov. 19X1	220	500	240	110	30			1,110
Dec. 19X1	150	600	300	100	75	$25		1,250
Jan. 19X2	210	750	375	105	60			1,500
Feb. 19X2	230	670	290	85	100	75		1,450
Totals	$960	$3,020	$1,405	$500	$315	$100		$6,300
Percentages:								
Monthly	15%	48%	22%	8%	5%	2%		
Cumulative	15%	63%	85%	93%	98%	100%		

Explanatory notes:

1. The above represents the first schedule that is prepared to determine the incurred and unreported claims for any month following February.
2. The schedule allocates claims as they are received to the month in which the service was performed. For example, in October, the plan received $150 of claims which had service dates in October (same month). Because this schedule begins in October, the $150 amount would be the only entry which the plan would be able to make in October. In November, the plan received $220 in claims which had service dates in November (same month), and $500 of claims which had service dates in October (second month). In December, the plan received $150 of claims which had service dates in December (same month), $500 of claims which had service dates in November (second month), and $200 in claims which had service dates in October (third month).

3. The schedule indicates that $6,300 in claims were received which had service dates of October through February. Of this amount, $960 was received during the month of service (same month), $3,020 in the following (second) month, $1,405 in the third month, $500 in the fourth month, etc. By converting these amounts to percentages of the total claims, the schedule indicates that on the average, 15% ($960 ÷ $6,300 =) of all claims incurred during any month are received in the same month, 48% are received in the following (second) month, for a cumulative total of 63% (15% + 48% =) of all claims incurring during any month being received in the same *and* second months. By employing these cumulative percentages, the amount incurred but unreported claims can be estimated as of July 31, after the claims information for the current but incomplete monthly periods is analyzed, as illustrated in the following schedule:

ABC HEALTH PLAN OF CALIFORNIA
SCHEDULE TO ESTIMATE THE AMOUNT OF INCURRED BUT UNREPORTED CLAIMS FOR THE CURRENT BUT INCOMPLETE MONTHLY PERIODS WHICH HAVE NOT BEEN FULLY OR SUBTANTIALLY REPORTED
JULY 31, 19X2

MONTH CLAIM RECEIVED

	Same Month	*Second*	*Third*	*Fourth*	*Fifth*	*Sixth*	*Seventh*	*Totals for Months of Service*
Month of Service:								
Mar., 19X2	$225	$720	$300	$120	$50			$1,415
April, 19X2	250	700	330	110				1,390
May, 19X2	240	750	350					1,340
June, 19X2	250	775						1,025
July, 19X2	270							270
Total claims received for period March 1 through July 31								$5,440

COMPUTATION OF INCURRED BUT UNREPORTED CLAIMS AS OF JULY 31

(A)	*(B)*	*(C)*	*(D)*	*(E)*
Month of Service	*Total claims received for each month of service as of July 31*	*Claims received as of July 31 as a cumulative percentage of total claims to be received*	*Total claims to be received (B—C)*	*Incurred But unreported (D—B)*
July	$270 (i)	15%	$1,800	$1,530
June	1,025 (ii)	63%	1,625	600
May	1,340 (iii)	85%	1,575	235
April	1,390 (iv)	93%	1,495	105
March	1,415 (v)	98%	1,440	25
February	1,450 (vi)	100%	1,450	0
Total incurred but unreported claims as of July 31				$2,495

Explanatory notes:
(i) Represents July claims received in July.
(ii) Represents June claims received in June and July.
(iii) Represents May claims received in May, June and July.
(iv) Represents April claims received in April, May, June and July.
(v) Represents March claims received in March, April, May, June and July.
(vi) Represents February claims received in February, March, April, May, June and July.

(d) An "actuarial estimate" is a calculation of incurred and unreported claims which is based on adequate and reasonable assumptions with respect to risk factors and trends which have been found to be applicable to the plan, such as utilization patterns of the plan's enrollees, the average benefit which will be payable, the enrollment mix in terms of age and sex of enrollees and geographic location, actual plan contract experience, and any other factors reasonably believed to affect the amount of incurred and unreported claims. Actuarial estimates must be supported by an actuarial certification, consisting of a signed declaration of any actuary who is a member in good standing of the American Academy of Actuaries in which such actuary states that the assumptions used in calculating the incurred and unreported claims are appropriate and reasonable. If the plan employs an actuarial study to estimate the amount of the incurred and unreported claims, it must compare the actual claims amounts to those estimated, and make adjustments at least quarterly whenever a 5% difference from actual experience is noted.

(e) A plan may employ any other unobjectionable alternative method of estimating the amount of incurred and unreported claims other than the "lag study" or "actuarial estimate", so long as such alternative method accurately estimates incurred and unreported claims. For example, a plan may receive daily reports of actual hospital admissions and referrals, thereby permitting the plan to compare these reports to the actual invoices and calculate the estimated amount due hospitals for the enrollees whose claims had not been received by the plan at that time.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

HISTORY:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).

1300.77.3. Report on Reimbursements Exceeding Ten Percent.

(a) Every plan which reimburses providers of health care services or subscribers and enrollees in the manner described in subdivision (a) or (b) of Section 1377 of the Act shall make and maintain as part of its records a computation for each calendar month and calendar quarter of reimbursements made, classified as provided in Section 1377, and showing the percentage of each class of reimbursements made to total expenditures for health care services during such month or quarter.

(b) When a report is required by subdivision (a) of Section 1377 of the Act, such report shall be filed with the Commissioner no later than 30 business days after the close of the calendar quarter.

(c) When a report is required by subdivision (b) of Section 1377 of the Act, such report shall be filed with the Commissioner no later than 30 business days after the close of the calendar month during which actual reimbursements made, or the amount estimated for incurred and unreported claims, exceeds 10 percent of its total expenditures for health care services.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1377, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).

1300.77.4. Reimbursements on a Fee-for-Services Basis: Determination of Status of Claims.

Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim. Although any categories for status-determination held unobjectionable by the Commissioner may be used, for the purposes of this section, the following status-determination categories, as a group, shall be presumptively reasonable: (1) to be processed, (2) processed, waiting for payment, (3) pending, waiting for approval for payment or denial, (4) pending, waiting for additional information, (5) denied, (6) paid, and, if appropriate, (7) other. These procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

HISTORY:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).

1300.78. Administrative Costs.

(a) For the purposes of Section 1378 of the Act, "administrative costs" include only those costs which arise out of the operation of the plan as such, excluding direct and overhead costs incurred in the furnishing of health care services which would be ordinarily incurred in the provision of such services whether or not through a plan. Administrative costs include the following:

(1) Salaries, bonuses and benefits paid or incurred with respect to the officers, directors, partners, trustees or other principal management of the Plan, less to the extent that such persons also are providers of health care services, the minimum reasonable cost of obtaining such services from others.

(2) The cost of soliciting and enrolling subscribers and enrollees, including the solicitation of group contracts, and including any indirect costs of enrollment borne on behalf of the plan by the holder of a group contract.

(3) The cost of receiving, processing and paying claims of providers of health care services and of claims for reimbursement by subscribers and enrollees, excluding the actual amount paid on such claims.

(4) Legal and accounting fees and expenses.

(5) The premium on the fidelity and surety bonds, and any insurance maintained pursuant to Section 1377, and any insurance or other expense incurred for the purposes of complying with Section 1375 of the Act. Malpractice insurance is not included within this subsection.

(6) All costs associated with the establishment and maintenance of agreements with providers of health care services, excluding the cost of reviewing quality and utilization of such services, and the cost of reviewing utilization of health care services on a referral basis.

(7) The direct or pro rata portion of all expenses incurred in the operation of the plan which are not essential to the actual provision of health care services to subscribers and enrollees, including but not limited to office supplies and equipment, clerical services, interest expense, insurance, dues and subscriptions, licenses (other than licenses for medical facilities, equipment or personnel), utilities, telephone, travel, rent, repairs and maintenance, depreciation of facilities and equipment, and charitable or other contributions.

(b) The administrative cost incurred by a plan, directly, as herein defined, shall be reasonable and necessary, taking into consideration such factors as the plan's stage of development and other considerations. If the administrative costs of an established plan exceed 15 percent, or if the administrative costs of a plan in the development phase exceed 25 percent, during any period of the revenue obtained by the plan from subscribers and enrollees, or paid to the plan on their behalf, the plan shall demonstrate to the Commissioner, if called upon to do so, that its administrative costs are not excessive administrative costs within the meaning of Section 1378 and are justified under the circumstances and/or that it has instituted procedures to reduce administrative costs which are proving effective. An established plan is a plan which has been in operation for a period of five years or more. For the purposes of Section 1378 of the Act, money borrowed will be deemed to be money derived from revenue obtained from subscribers and enrollees to the extent that such revenue is exposed to liability for repayment of such borrowings or that repayment is anticipated from such revenues and "money not derived from" such revenues includes only net assets arising independently of the operation of the plan and not traceable on a historical basis to such revenues, whether as net profit or otherwise.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1378, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).

Article 10. Medical Surveys

1300.80. Medical Survey Procedure.

(a) Unless the Commissioner in his discretion determines that advance notice will render the survey less useful, a plan will be notified approximately four weeks in advance of the date for commencement of an onsite medical survey. The Commissioner may, without prior notice, conduct inspections of plan facilities or other elements of a medical survey, either in conjunction with the medical survey or as part of an unannounced inspection program.

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.

(1) Review of the procedures for obtaining health services including, but not limited to, the scope of basic health care services.

(A) The availability and adequacy of facilities for telephone communication with health personnel, emergency care facilities, out-of-the-area coverage, referral procedures, and medical encounters.

(B) The means of advising enrollees of the procedures to obtain care, including the hours of operation, location and nature of facilities, types of care, telephone and other arrangements for appointment setting.

(C) The availability of qualified personnel at each facility referred to in Section 1368(b) to receive and handle inquiries concerning care, plan contracts, and grievances.

(2) Review of the design and implementation of procedures for reviewing and regulating utilization of services and facilities.

(3) Review of the design and implementation of procedures to review and control costs.

(4) Review of the design, implementation and effectiveness of the internal quality of care review systems, including review of medical records and medical records systems. A review of medical records and medical records systems may include, but is not limited to, determining whether:

(A) The entries establish the diagnosis stated, including an appropriate history and physical findings;

(B) The therapies noted reflect an awareness of current therapies;

(C) The important diagnoses are summarized or highlighted; (Important are those conditions that have a bearing on future clinical management.)

(D) Drug allergies and idiosyncratic medical problems are conspicuously noted;

(E) Pathology, laboratory and other reports are recorded;

(F) The health professional responsible for each entry is identifiable;

(G) Any necessary consultation and progress notes are evidenced as indicated;

(H) The maintenance of an appropriate system for coordination and availability of the medical records of the enrollee, including out-patient, in-patient and referral services and significant telephone consultations.

(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

(A) The numbers and qualifications of health professional and other personnel;

(B) The provision of, incentives for, and participation in, continuing education for health personnel and the provision for access to current medical literature;

(C) The adequacy of all physical facilities, including lighting, cleanliness, maintenance, equipment, furnishings, and convenience to enrollees, plan personnel and visitors;

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

(E) The appropriate functioning of health professionals and other health personnel, including specialists, consultants and referrals;

(F) Nursing practices, including reasonable supervision;

(G) Written nondiscriminatory personnel practices which attract and retain qualified health professionals and other personnel;

(H) The adequacy and utilization of pathology and other laboratory facilities, including the quality, efficiency and appropriateness of laboratory procedures and records and quality control procedures;

(I) X-ray and radiological services, including staffing, utilization, equipment, and the promptness of interpretation of X-ray films by a qualified physician;

(J) The handling and adequacy of medical record systems, including filing procedures, provisions for maintenance of confidentiality, the efficiency of procedures for retrieval and transmittal, and the utilization of sampling techniques for medical records audits and quality of care review;

(K) The adequacy, including convenience and readiness of availability to enrollees, of all provided services;

(L) The organization of the plan and its mechanisms for furnishing health care services, including the supervision of health professionals and other personnel;

(M) The extent to which individual medical decisions by qualified medical personnel are unduly constrained by fiscal or administrative personnel, policies or considerations;

(N) The adequacy of staffing, including medical specialties.

(6) Review of the overall performance of the plan in meeting the health needs of enrollees.

(A) Accessibility of facilities and services, based upon location of facilities, hours of operation, waiting periods for services and appointments, including elective services, the availability of parking and transportation;

(B) Continuity of care, including the ability of enrollees to select a primary care physician, staffing in medical specialties or arrangements therefor; the referral system (including instructions, monitoring and follow-up); the maintenance and ready availability of medical records; and the availability of health education to enrollees;

(C) The grievance procedure required by Section 1368 of the Act, including the availability to enrollees and subscribers of grievance procedure information, the time required for and the adequacy of the response to grievances and the utilization of grievance information by plan management.

(7) In considering the above and in pursuit of the survey objectives, the survey team may perform any or all of the following procedures:

(A) Private interviews and group conferences with enrollees, physicians and other health professionals, and members of its administrative staff including, but not limited to, its principal management persons.

(B) Examination of any records, books, reports and papers of the plan and of any management company, provider or subcontractor providing health care or other services to the plan including, but not limited to, the minutes of medical staff meetings, peer review, and quality of care review records, duty rosters of medical personnel, surgical logs, appointment records, the written procedures for the internal operation of the plan, and contracts and correspondence with enrollees and with providers of health care services and of other services to the plan, and such additional documentation the Commissioner may specifically direct the surveyors to examine.

(C) Physical examination of facilities, including equipment.

(D) Investigation of grievances or complaints from enrollees or from the general public.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1380, Health and Safety Code.

HISTORY:

1. Amendment of subsection (b) (7) (D) filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

1300.80.10. Medical Survey: Report of Correction of Deficiencies.

Prior to or immediately upon the expiration of the 30-day period following notice to a plan of a deficiency as provided in subdivision (h) of Section 1380 of the Act, the plan shall file a written statement with the Commissioner identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The report shall be signed by a principal officer of the plan.

Where such deficiencies may be reasonably adjudged to require long-term corrective action or to be of a nature which may be reasonably expected to require a period longer than 30 days to remedy, in some instances evidence that the plan has initiated remedial action and is on the way to achieving acceptable levels of compliance may be submitted.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1380, Health and Safety Code.

HISTORY:

1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

Article 11. Examinations

1300.81. Removal of Books and Records From State.

The books and records of a plan, management company, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, or solicitor firm shall not be removed from this state without the prior consent of the Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1381, Health and Safety Code.

HISTORY:

1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

1300.82. Examination Procedure.

Regular and additional or nonroutine examinations conducted by the Department pursuant to Section 1382 will ordinarily be commenced on an unannounced basis. To the extent feasible, deficiencies noted will be called to the attention of the responsible officers of the company under examination during the course of the examination, and in that event the company should take the corrective action indicated. When deemed appropriate, the company will be advised by letter of the deficiencies noted upon the examination. If the deficiency letter requires a report from the company, such report must be furnished within 15 days or such additional time as may be allowed.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1382, Health and Safety Code.

HISTORY:

1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

1300.82.1. Additional or Nonroutine Examinations and Surveys

(a) An examination or survey is additional or nonroutine for good cause for the purposes of Section 1382(b) when the reason for such examination or survey is any of the following:

(1) The plan's noncompliance with written instructions from the Department;

(2) The plan has violated, or the Commissioner has reason to believe that the plan has violated, any of the provisions of Sections 1352, 1370, 1375.1, 1376, 1384 and 1385 of the Act and Sections 1300.76, 1300.80.10, 1300.81, 1300.82(a), 1300.84.2 and 1300.84.3 of these regulations.

(3) The plan has committed, or the Commissioner has reason to believe that the plan has committed, any of the acts or omissions enumerated in Section 1386 of the Act.

(4) The Commissioner deems such additional or nonroutine examination or survey necessary to verify representations made to this Department by a plan in response to a deficiency letter.

(b) Each situation giving rise to an additional or nonroutine examination or survey shall be evaluated on a case-by-case basis as to the seriousness of the violation, or lack of timely or adequate response by the plan to the Department's request to correct the violation. The plan shall be notified in writing of the provisions of the Act or regulations which have been, or may have been, violated and which therefore caused such additional or nonroutine examination or survey to be performed. The expense of such examinations and surveys shall be charged to the plan being examined or surveyed in accordance with Section 1382(b).

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352, 1370, 1375.1, 1376, 1380, 1382, 1384, 1385 and 1386, Health and Safety Code.

HISTORY:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).

Article 12. Reports

1300.83. Annual Report.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1979, Ch. 1083.

HISTORY:

1. Repealer filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

1300.84. Financial Statements.

(a) Whenever pursuant to these rules or pursuant to an order or request of the Commissioner pursuant to the Act a financial statement or other report is required to be audited or be accompanied by the opinion of a certified public accountant or public accountant, such accountant shall be independent of the licensee, determined in accordance with Accounting Series Release Number 126 issued by the Securities and Exchange Commission.

(b) The financial statements required under subsections (a), (b) and (c) of Section 1384 of the Act shall be audited by an independent accountant in accordance with Section 1300.45(e).

(c) Except as provided in subsection (d), financial statements of a plan required pursuant to these rules must be on a combining basis with an affiliate, if the plan or such affiliate is substantially dependent upon the other for the provision of health care, management or other services. An affiliate will normally be required to be combined, regardless of its form of organization, if the following conditions exist:

(1) The affiliate controls, is controlled by, or is under common control with, the plan, either directly or indirectly (see subsections (c) and (d) of Section 1300.45), and

(2) The plan or the affiliate is substantially dependent, either directly or indirectly, upon the other for services or revenue.

(d) Upon written request of a plan, the Commissioner may waive the requirement that an affiliate be combined in financial statements required pursuant to these rules. Normally, a waiver will be granted only when (1) the affiliate is not directly engaged in the delivery of health care services or (2) the affiliate is operating under an authority granted by a governmental agency pursuant to which the affiliate is required to submit periodic financial reports in a form prescribed by such governmental agency that cannot practicably be reformatted into the form prescribed by these rules (such as an insurance company).

(e) When combining financial statements are required by this section, the independent accountant's report or opinion must cover all the entities included in the combining financial statements. If the accountant's report or opinion makes reference to the fact that a part of the examination was performed by another auditor, the plan shall also file the individual financial statements and report or opinion issued by the other auditor.

(f) Plans which have subsidiaries that are required to be consolidated under generally accepted accounting principles must present either (1) consolidating financial statements, or (2) consolidating schedules for the balance sheet and statement of operations, which in either case must show the plan separate from the other entities included in the consolidated balances.

(g) This section shall not apply to a plan which is a public entity or political subdivision.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. Amendment filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

1300.84.05. Change of Independent Accountant.

Whenever the financial statements required pursuant to subdivisions (a), (b) or (c) of Section 1384 are to be reported upon or certified by an accountant other than the accountant certifying the plan's most recent filing, the plan must furnish the Commissioner with a separate letter stating whether in the eighteen (18) months preceding the engagement of the new accountants there was any disagreement with the former accountants on any matter of accounting principles or practices, financial statement disclosure or auditing procedures, which such disagreement if not resolved to the satisfaction of the former accountants would have caused him to make reference to the subject matter of such disagreement in his opinion or report. This letter must be verified by a principal officer of the plan as prescribed by Section 1300.84.1. The plan shall also request the former accountants to furnish them with a letter addressed to the Commissioner stating whether he agrees with the statements contained in the letter of the plan and, if not, stating the respects in which he does not agree. The notification by the plan along with the former accountant's letter, if necessary, must be furnished to the Commissioner within 45 days of the engagement of the new accountants.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345 and 1384, Health and Safety Code.

HISTORY:

1. New section filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).

1300.84.06. Plan Annual Report.

The annual report required of a plan pursuant to subdivision (c) of Section 1384 of the Act shall include or be accompanied by the following:

(a) Sufficient and appropriate supplemental information to provide adequate disclosure of at least the following:

(1) The provision for incurred and unreported claims and an explanation of the method of calculating such provision.

(2) Accounts and notes receivable from officers, directors, owners or affiliates, including the name of the debtor, nature of the relationship, nature of the receivable and its terms.

(3) Donated materials or services received by the plan for the period of the financial statements and the donor's name and affiliation with the plan, together with an explanation of the method used in determining the valuation of such materials or services.

(4) Forgiven debt or obligations during the period of the financial statements, including the creditor's name and affiliation with the plan and a summary of how the obligation arose.

(5) Provider withhold, incentive withhold, or risk pool retained by the plan for the period of the financial statements, and the current amount thereof.

(b) A calculation of the plan's tangible net equity in accordance with Section 1300.76, and a statement of the number of enrollees in the plan.

(c) The following information, for the twelve-month period:

(1) The total amount of administrative costs as defined in Section 1300.78.

(2) The percentage of such administrative costs to revenue obtained from subscribers and enrollees.

(3) The amount of total expenditures for health care services.

(4) Total payments to noncontracting providers and the total amount of reimbursements to subscribers and enrollees, for the four-month and for the six-month periods preceding the date of the report.

(5) The amount of copayments paid to contracting providers by subscribers and enrollees.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

1300.84.1. Verification of Reports.

Each report required to be furnished by a plan pursuant to this article shall be verified by a principal officer of the plan. The verification may be under penalty of perjury if executed in California; otherwise such report shall be sworn to before and notarized by a notary public.

1300.84.2. Quarterly Financial Reports.

Within 45 days after the close of each quarter of its fiscal year, each licensed plan shall file with the Commissioner its report consisting of the following information:

(a) Financial statements (which need not be certified) prepared in accordance with generally accepted accounting principles, prepared on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c) of the Act (unless the plan receives the written approval of the Commissioner to vary from that basis and such variance is adequately noted in its report under this section). Such financial statements shall include:

(1) A balance sheet of the plan as of the closing date of such quarter.

(2) An income statement or statement of operations for such quarter.

(3) A statement of changes in financial position for such quarter.

(4) The information required pursuant to Section 1300.84.06(a) for such quarter.

(b) A calculation of the plan's tangible net equity as of the closing date of such quarter and a statement of the number of enrollees in the plan.

(c) The information required pursuant to Section 1300.84.06(c) (other than subsection (4) thereof) for such quarter, and the information required by subsection (4) thereof for the four-month and six-month periods preceding the closing date of such quarter.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. Amendment filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

1300.84.3. "Early Warning" Reports.

(a) Each plan shall maintain internal procedures which provide one or more of its principal officers on at least a monthly basis with the information necessary for the report required pursuant to this section.

(b) Each plan shall report to the Commissioner the increase during any calendar quarter of the amount owed by the plan to providers for health care services, if the amount of such increase exceeds 10 percent of the amount owed at the close of the previous quarter. In the event the amount owed to a provider is disputed, the amount claimed as due by the provider shall control for the purposes of this section. This report shall be filed within 30 days after the close of the quarter for which the report is made.

(c) Each plan shall promptly advise the Commissioner of any extraordinary loss, or of any claim whether or not admitted by the plan or a contingent claim, which (1) renders the plan unable to meet its obligations as they become due, or (2) reduces (or would reduce) the tangible net equity of the plan below the amount required by Rule 1300.76.

(d) Each plan shall, upon the occurrence of any of the events specified below, file a report with the Commissioner within 30 business days of the close of the month for which such condition is noted, and each month thereafter until notified by the Commissioner to discontinue such reports. Each such report shall consist of a balance sheet and statement of operations of the plan, which need not be certified, and a calculation of tangible net equity in accordance with Rule 1300.76. The events the occurrence of which shall require reporting under this section are the following:

(1) The tangible net equity of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), is less than 200% of the minimum tangible net equity required by Rule 1300.76.

(2) The aggregate liabilities of the plan (excluding liabilities which have been subordinated in a manner acceptable to the Commissioner), individually or on a combined basis with affiliates (Rule 1300.84(c)), exceed four times its tangible net equity, computed in accordance with Rule 1300.76.

(3) The statement of operations of the plan, individually or on a combined basis with affiliates (Rule 1300.84(c)), reflects a loss during any month the amount of which exceeds the difference between the tangible net equity of the plan (or the combined entity) as of the end of such month and the minimum net equity required by Rule 1300.76.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. Amendment of subsection (d) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (d) filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

1300.84.4. Financial Reports by Solicitor Firms.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Repealer filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

1300.84.5. Public Entity Plans.

(a) A plan which is a public entity or political subdivision shall be subject to the provisions of this section.

(1) Financial statements of a plan which is a public entity or political subdivision, including financial statements or reports of specific funds or groups of accounts where health plan activity is recorded, which are required to be submitted pursuant to Section 1351(h) or 1384(c) of the Act or by rule, order or request of the Commissioner, shall be accompanied either by an opinion of a certified public accountant or public accountant or by a report of a government audit organization.

(2) For the purposes of Sections 1351 and 1384, governmental auditing standards are defined to include the standards set forth in this item. Every audit which results in the opinion or report referred to in Item (1) of this subsection shall be conducted in accordance with the governmental auditing standards indicated below:

(A) General Standards:

(i) The auditors assigned to perform the audit must collectively possess adequate professional proficiency for the tasks required.

(ii) In all matters relating to the audit work, the audit organization and the individual auditors, whether government or public, must be free from personal or external impairments to independence, must be organizationally independent, and shall maintain an independent attitude and appearance.

(iii) Due professional care is to be used in conducting the audit and in preparing related reports.

(B) Standards of Field Work:

(i) The work is to be adequately planned and assistants, if any, are to be properly supervised.

(ii) There is to be a proper study and evaluation of the existing internal control as a basis for reliance thereon and for the determination of the resultant extent of the tests to which auditing procedures are to be restricted.

(iii) Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under examination.

(C) Standards of Reporting:

(i) The report shall state whether the financial statements are presented in accordance with generally accepted accounting principles.

(ii) The report shall state whether such principles have been consistently observed in the current period in relation to the preceding period.

(iii) Informative disclosures in the financial statement are to be regarded as reasonably adequate unless otherwise stated in the report.

(iv) The report shall either contain an expression of opinion regarding the financial statements, taken as a whole, or an assertion to the effect that an opinion cannot be expressed. When an overall opinion cannot be expressed, the reasons therefor should be stated. In all cases where an auditor's name is associated with financial statements, the report should contain a clear-cut indication of the character of the auditor's examination, if any, and the degree of responsibility he is taking.

(D) Additional Standards and Requirements on Examination and Evaluation for Government Financial and Compliance Audits.

(i) Planning shall include consideration of the requirements of all levels of government.

(ii) A review is to be made of compliance with applicable laws and regulations.

(iii) A written record of the auditors' work shall be retained in the form of working papers.

(iv) Auditors shall be alert to situations or transactions that could be indicative of fraud, abuse, and illegal expenditures and acts and if such evidence exists, extend audit steps and procedures to identify the effect on the entity's financial statements.

(E) Additional Standards and Requirements on Reporting for Government Financial and Compliance Audits.

(i) Written audit reports are to be submitted to the appropriate officials of the organization audited and to the appropriate officials of the organizations requiring or arranging for the audits unless legal restrictions or ethical considerations prevent it. Copies of the reports should also be sent to other officials who may be responsible for taking action and to others authorized to receive such reports. Unless restricted by law or regulations, copies should be made available for public inspection.

(ii) A statement in the auditors' report that the examination was made in accordance with generally accepted government auditing standards for financial and compliance audits will be acceptable language to indicate that the audit was made in accordance with these standards.

(iii) Either the auditors' report on the entity's financial statements or a separate report shall contain a statement of positive assurance on those items of compliance tested and negative assurance on those items not tested. It shall also include material instances of noncompliance and instances or indications of fraud, abuse, or illegal acts found during or in connection with the audit.

(iv) The auditors shall report on their study and evaluation of internal accounting controls made as part of the financial and compliance audit. They shall identify as a minimum: (a) the entity's significant internal accounting controls, (b) the controls identified that were evaluated, (c) the controls identified that were not evaluated (the auditor may satisfy this requirement by identifying any significant classes of transactions and related assets not included in the study and evaluation), and (d) the material weaknesses identified as a result of the evaluation.

(v) Either the auditors' report on the entity's financial statements or a separate report shall contain any other material deficiency findings identified during the audit not covered in (ii) above.

(vi) If certain information is prohibited from general disclosure, the report shall state the nature of the information omitted and the requirement that makes the omission necessary.

(3) Financial statements, including reports of specific funds or groups of accounts, which are to be submitted pursuant to this section must be previously approved as to form by the Commissioner. When all health plan activity has been separately controlled and accounted for in an Enterprise Fund, the financial statements or reports of such funds are presumptively approved as to form for purposes of this subsection.

(b) A plan which is a public entity or political subdivision shall be granted a total or partial exemption from Sections 1300.84.06 and 1300.84.2 upon proper application therefor, when and to the extent that

(1) the Commissioner determines that such plan has demonstrated that the information set forth in Sections 1300.84.06 and 1300.84.2 is neither available to the plan nor necessary for its internal management and cannot be produced without significant cost to the plan, and

(2) such plan undertakes to furnish alternative information which the Commissioner finds to be reasonable and adequate in view of the circumstances of the plan.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1351, 1384 and 1385, Health and Safety Code.

HISTORY

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

1300.84.6. Plan Annual Enrollee Report.

(a) On or before September 15th of each year, each licensed plan shall file a report in the following form and containing the information specified therein:

Department of Corporations
State of California

Dept. of Corporations
File Number

REPORT OF
FAMILY UNITS ENROLLED IN PLAN
Knox-Keene Health Care Service Plan Act

1. Name of Plan:

2. Name, telephone number and mailing address of Plan official to whom communications concerning this report should be addressed.

Name ( ) Phone—include area code

Number and street or P. O. box

City, state and zip code

3. For the purposes of Section 1356(b) of the Knox-Keene Health Care Service Plan Act, the Plan reports that, as of June 30 of the year in which this report is made, its records reflected the following enrollments, in accordance with the definitions contained in Section 1300.84.6, Title 10, California Administrative Code:

Number of subscribers _____
Number of enrollees _____
Number of family units _____
(Note: The number of subscribers and family units must be determined by actual count. The number of enrollees may be estimated if the actual count is not available.)

4. Execution: I certify under penalty of perjury that the above statement is true.
Executed at _____ (City and state) on _____ (Date)

_____
Print or type name of declarant

_____
Signature of declarant

_____
Position with Plan

(b) For the purposes of this rule and Section 1356(b) of the Act, "family unit" is defined as a unit composed of a subscriber and each person whose eligibility for benefits is based upon such person's relationship with, or dependency upon, such subscriber. The words "enrollee" and "subscriber" are defined in Subdivisions (c) and (o) of Section 1345 of the Act.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1356, 1384, 1385, Health and Safety Code.

HISTORY:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

1300.84.7. Special Reports Relating to Charitable or Public Activities.

(a) Any plan whose purposes involve any charitable or public purposes shall provide a special report to the Commissioner upon filing with the Attorney General any notice, request, or other materials pursuant to any law administered by the Attorney General and relating to matters which will or may have any financial effect on or implications for the plan. Such special report shall include the information provided to the Attorney General together with representations as to whether the transactions, actions, or other facts set forth in the materials submitted to the Attorney General will or may have any deleterious effect on the financial condition of the plan.

(b) Any plan whose purposes involved any charitable or public purposes shall provide a special report to the Commissioner upon engaging in any transaction to which the corporation is a party and in which one or more of its directors has a material financial interest, if such transaction will or may have any material financial effect on or implications for the plan. Such special report shall specifically describe the transaction and shall contain representations as to whether the transaction will or may have any deleterious effect on the financial condition or operations of the plan.

(c) Any filing pursuant to this section may be combined with any appropriate filings pursuant to Article 2, Part 11, Division 2, Title 1 of the Corporations Code and may utilize common exhibits, subject to the provisions of Section 1300.824(c).

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. New section filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).

Article 13. Books and Records

1300.85. Books and Records.

(a) Each plan, solicitor firm, and solicitor shall keep and maintain their books of account and other records on a current basis.

(b) Each plan shall make or cause to be made and retain books and records which accurately reflect:

(1) The names and last known addresses of all subscribers to the plan.

(2) All contracts required to be submitted to the Department and all other contracts entered into by the plan.

(3) All requests made to the plan for payment of moneys for health care services, the date of such requests, and the dispositions thereof.

(4) A current list of the names and addresses of all individuals employed by it as a solicitor.

(5) A current list of the names and addresses of all solicitor firms with which it contracts.

(6) A current list of the names and addresses of all of the plan's officers, directors, principal shareholders, general managers, and other principal persons.

(7) The amount of any commissions paid to persons who obtain members for plans and the manner in which said commissions are determined.

(c) Each solicitor firm shall make and retain books and records which include a current list of the names and addresses of its partners, if any, and all of its employees who may act as solicitors.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1385, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

1300.85.1. Retention of Books and Records.

Every plan and solicitor firm shall preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan or solicitor firm, the books of account and other records required under the provisions of, and for the purposes of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Commissioner within not more than 5 days after request therefor.

Article 14. Miscellaneous Provisions

1300.89. Petition for Restoration.

(a) The fee for the filing of a petition for restoration shall be $100 for a solicitor, $250 for a solicitor firm, and $500 for a plan.

(b) A petition for restoration shall be made upon the following form:

(Official Use Only)

Fee Paid $_____

Receipt No. _____

DEPARTMENT OF CORPORATIONS
File No. _____
(Insert file number of previous filings before the Department, if any.)

FILING FEE: Solicitor: $100
Solicitor firm: $250
Plan: $500
Not refundable except pursuant to Section 250.15, Title 10, California Administrative Code.

EXECUTION PAGE

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

PETITION FOR RESTORATION
UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

INDICATE TYPE OF FILING BY CHECKING ONE OF THE FOLLOWING:
- ☐ ORIGINAL PETITION FOR SOLICITOR
- ☐ ORIGINAL PETITION FOR SOLICITOR FIRM
- ☐ ORIGINAL PETITION FOR PLAN
- ☐ AMENDMENT TO PETITION FOR SOLICITOR
- ☐ AMENDMENT TO PETITION FOR SOLICITOR FIRM
- ☐ AMENDMENT TO PETITION FOR PLAN

1. Name of petitioner (Complete name as appearing on articles of incorporation, partnership agreement, etc.)

2. Address of principal office of petitioner.
(Number and Street) (City) (State) (Zip Code)

3. Address of principal office of petitioner in the State of California.
(Number and Street) (City) (State) (Zip Code)

4. Name and address of person to whom communications should be addressed concerning this petition.

5. The petitioner undertakes to furnish as an amendment to this petition, within 20 days of receipt of a request therefor, such additional information as the Commissioner may require pursuant to subsection (c) of this section.

EXECUTION

The petitioner has duly caused this petition to be signed on its behalf by the undersigned, thereunto duly authorized.

_____ By: _____
(Petitioner) Title: _____

I certify under penalty of perjury that I have read this petition and the exhibits and attachments thereto and know the contents thereof, and that the statements therein are true.

Executed at _____ on _____, 19____
(City) (State)

_____
(Signature of Declarant)

(If executed other than in a state which permits verifications under penalty of perjury, attach a verification executed and sworn to before a Notary Public.)

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6. Name and address of officer or partner of petitioner who is to receive compliance and informational communications from the Department, and who is responsible for disseminating the same within the petitioner's organization.

7. Set forth the grounds upon which the license, employment, or activity was suspended, revoked, or barred.

8. Set forth the basis upon which petitioner believes that restoration is warranted.

9. Set forth the steps which petitioner has taken to prevent a recurrence of the grounds referred to in item 6, above, and any other information which petitioner believes to be relevant.

10. If the petitioner is a plan, is its application on file with the Department current without the need for any amendment?

☐ Yes ☐ No

If "no", state the day on which petitioner will comply with subsection (c) of this section.

11. If the petitioner is a plan, attach as exhibits all current reports, information, and statements which are required to be filed under the Act or rules but which have not been filed to date.

12. If the petitioner is a solicitor firm, describe the organization of petitioner, identify its principal persons, and describe the manner in which it proposes to act as a solicitor firm.

13. If the petitioner is a solicitor firm, attach financial statements as indicated.

(a) If petitioner is subject to the tangible net worth requirement of Section 1300.76.2, Title 10, Calif. Admin. Code, attach a copy of petitioner's financial statement consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition. Such financial statement need not be certified, but if not certified, also attach as an exhibit certified financial statements of the petitioner as of the close of its last fiscal year.

If petitioner is exempted from Section 1300.76.2 by subsection (b) of that section (accepting only funds in the form of checks payable to plans, subscribers or other persons contracting with plans and forwarding such checks to the payee by the close of the business day following receipt thereof), attach a statement to that effect and attach a copy of petitioner's financial statement, which need not be certified, consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition.

If petitioner accepts no funds, in the form of checks or otherwise, of plans, subscribers or other persons contracting with plans (exclusive of petitioner's compensation for its solicitation activities), attach a statement to that effect, and do not include financial statements of the petitioner as an exhibit to the petition.

(c) If the petition provided in subsection (b) is filed by a plan, such plan shall file an amendment to its application on file with the Department which will bring that application current, or, if its application is current without the need for any amendment, it shall so allege.

(d) Depending upon the nature of the matter, the Commissioner may require additional information and/or undertakings as a condition of granting a petition for restoration in order to determine whether such person, if restored, would engage in business in full compliance with the objectives and provisions of the Act and the rules thereunder.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1389, Health and Safety Code.

HISTORY:

1. New section filed 1-12-83, effective thirtieth day thereafter (Register 83, No. 3).

1300.99. Application to Surrender License.

An application to surrender a license as a health plan shall be filed with the Commissioner, in the following form:

DEPARTMENT OF CORPORATIONS
STATE OF CALIFORNIA

APPLICATION FOR SURRENDER OF LICENSE
PURSUANT TO
SECTION 1399, HEALTH AND SAFETY CODE

Date of Application _____

Dept. of Corporations
File No. _____

1. Name of Licensee (as appearing in license)
   _____
2. Person to be contacted regarding this application:
   Name _____
   Address _____
   _____
   Telephone Number _____
3. Reason for Surrender of License (explain briefly):
4. Date upon which licensee proposes to terminate business:
   _____
   If the date is subject to contingencies or will be determined hereafter, explain briefly below:
5. Complete the following:
   a. Attach a copy of the balance sheet and a statement of income and expense for the plan, prepared as of a date within 30 days of the filing of this application. Such financial statements need not be certified.
   b. State whether the licensee is required to file certain reports pusuant to Section 1384 of the Knox-Keene Health Care Service Plan Act of 1975.
   If so, state the date by which the licensee will forward such reports to the Commissioner:
   _____
   c. Section 1300.85.1 of the rules pursuant to the Knox-Keene Health Care Service Plan Act of 1975 requires that the books and records of a plan be preserved for a period of five years.
   State the name and address of the custodian of the plan's books and records and the address at which such records will be located:

Custodian: _____

_____

Location: _____

_____

d. Describe in an attachment hereto the licensee's plans for the termination of its business as a health care service plan or specialized health care service plan, including the following information:

1. The provision for payment of any amounts due to subscribers and enrollees and the aggregate amount owed thereto.
2. The provision for payment of any amounts due to providers of health care services, the aggregate amount owed thereto and a schedule showing the persons to whom such amounts are owed, the amount due each such person, and the date such liability first became due and payable.
3. The final date for payment of periodic payments by or on behalf of subscribers for health care services, and the final date which the plan will be obligated to furnish health care services by reason of such payments.
4. If an insurer assumes obligations as to the plan's subscribers and enrollees, attach a detailed statement of the plan for the assumption of business by the subsequent provider or insurer, including the provision being made for notice to subscribers and enrollees, group representatives and providers of health care services who contract with the plan.
5. If the plan or any provider of health care services to the plan holds medical records as to any subscriber or enrollee, indicate the disposition to be made of such records, including the provision made for its subsequent availability to persons providing health care services to such subscribers and enrollees.

e. Is the plan's application pursuant to Section 1351 of the Knox-Keene Health Care Service Plan Act of 1975 current, reflecting all matters which require an amendment to such application pursuant to Rules 1300.52, 1300.52.1 or 1300.52.2?

Yes ☐ No ☐

If "no" attach an amendment(s) to such application in conformance with such rules.

f. Is the plan currently involved in any civil or administrative proceeding?

Yes ☐ No ☐

If "yes" furnish full details, including the court or administrative action before which such matter is pending.

6. The licensee has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

_____
(Licensee)

By _____

Title _____

I certify under penalty of perjury that I have read this application and the attachments hereto and know the contents thereof, and that the statements therein are true.

Executed at _____ on _____ 19__

_____
Signature of Declarant

If executed in a jurisdiction which does not permit verification under penalty of perjury, attach a verification executed and sworn to before a notary public.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1399, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

Article 15. Charitable or Public Activities

1300.824. Requirements Relating to Charitable or Public Activity Filings.

(a) In addition to Article 2, Part 11, Division 2, Title 1 of the Corporations Code, plans subject to requirements relating to charitable or public purposes are subject to a variety of other statutory provisions, including some, such as Sections 5236 and 7240 of the Corporations Code, which expressly subject certain plans to the jurisdiction of the Attorney General. No action of the Commissioner pursuant to Section 10824 or 10826 of the Corporations Code will exempt any plan from any statutory provision otherwise applicable to it.

(b) For the purposes of voluntarily giving notice or submitting requests for rulings or approval to the Commissioner pursuant to the provisions of this article or Article 2, Part 11, Division 2, Title 1 of the Corporations Code, all notices and requests shall be submitted in writing addressed to the Commissioner in care of the Health Care Service Plan Division in the Commissioner's Los Angeles office. Said written notices or requests shall be deemed to be filed with the Commissioner only when the notices or requests are received by the Health Care Service Plan Division in the Commissioner's Los Angeles office. A conformed copy of the notice or request or of the cover letter accompanying such notice or request, along with a self-addressed, postage prepaid envelope, may be submitted to the Commissioner with the original, to be stamped "received" with the date of such receipt stamped thereon and returned to the sender.

(c) A notice and/or request under this article may be combined with a submission under Section 1352 or other provision of the Act or a special report under Section 1300.84.7(b) and may utilize common exhibits, so long as the plan submits with respect to each statutory function a separate, cross-referenced cover letter citing the appropriate statutory authority, incorporating by reference the pertinent exhibits, and indicating the intent of the plan and the action, if any, being requested of the Commissioner.

(d) All notices and requests submitted pursuant to this article or Article 2, Part 11, Division 2, Title 1 of the Corporations Code are deemed to be "applications" for the purposes of public disclosure or confidential treatment as provided by Sections 250.9, 250.9.1, 250.10, and 250.10.5 of the Commissioner's rules.

(e) This article shall apply to a mutual benefit corporation only to the extent that a mutual benefit corporation holds assets in charitable trust.

NOTE: Authority cited: Sections 10824 and 10826, Corporations Code. Reference: Sections 7238, 10824 and 10826, Corporations Code.

HISTORY:

1. New Article 15 (Sections 1300.824–1300.826, not consecutive) filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).

1300.824.1. Notices and Requests for Approval of Certain Transactions.

(a) A written notice of a transaction voluntarily submitted to the Commissioner under Section 10824(e) of the Corporations Code shall expressly state that it is a notice of a transaction under Section 10824(e) of the Corporations Code. A written statement notifying the Commissioner of certain facts or transactions pursuant to Section 1352 or other provision of the Act or Section 1300.84.7, requesting the approval of the Commissioner under Section 10824(d), requesting a ruling of the Commissioner under Section 10826, or being submitted for any other purpose shall not be deemed to be a notice of a transaction under Section 10824(e) of the Corporations Code unless it expressly so states and complies with applicable requirements.

(b) A written notice of a transaction voluntarily submitted to the Commissioner under Section 10824(e) shall contain at least the following:

(1) A letter signed on behalf of the corporation by an authorized director or officer thereof or by or on behalf of a director or officer of the corporation and addressed as indicated in Section 1300.824(b), setting forth a detailed description of the transaction (including the date and place thereof), the extent to which any director has a material financial interest in the transaction, and all material facts regarding the transaction.

(2) A copy of the corporation's current financial statement as of a date within ninety days preceding the filing of the notice or request, except to the extent already on file with the Health Care Service Plan Division.

(3) A copy of the articles of incorporation and amendments thereto of the corporation, except to the extent already on file with the Health Care Service Plan Division.

(c) A request for the approval of the Commissioner of a self-dealing transaction under Section 10824(d) of the Corporations Code may be submitted with a notice under Subsection (a), shall expressly request such approval, and shall contain the information required by items (1), (2), and (3) of Subdivision (b), plus at least the following:

(1) A copy of the bylaws and amendments thereto of the corporation, except to the extent already on file with the Health Care Service Plan Division.

(2) Copies of all minutes of meetings of the board of directors and of committees of the board of directors which reflect any discussions or evaluations of the transaction.

(3) A letter signed by the interested director setting forth a description of the director's material financial interest in the transaction, listing all material facts concerning the transaction and all facts disclosed by the interested director to the board of directors concerning the transaction. The interested director's letter may expressly incorporate by reference any named parts or all of the corporation's letter.

(4) Such additional information as the Commissioner may require. The Commissioner may require, among other things, a signed and dated opinion of counsel admitted to practice law in the State of California, supported by a reasoned discussion of the pertinent facts and authorities, as to any or all of the following issues:

(A) Whether the corporation entered the transaction solely for its own benefit;

(B) Whether the transaction is fair and reasonable as to the corporation at the time the corporation entered or will enter the transaction;

(C) Whether the transaction is consistent or inconsistent with the requirements of a charitable trust;

(D) Whether the corporation or any of its officers or directors may have been negligent or fraudulent in connection with the transaction;

(E) Such additional issues as the Commissioner may specify.

(d) For the purposes of this section, "material facts" shall include at least a description of the personal or real property or services to be provided to or by the corporation pursuant to the transaction, the price for the personal or real property or services to be paid by or to the corporation, the estimated fair market value of the personal or real property or services, the benefit which the transaction will confer upon the corporation, whether the board of directors of the corporation has approved the transaction, the factual basis of any such approval by the board of directors, the disclosure made to the board of directors by the interested director, the alternative transactions (if any) which were considered by the board of directors and why they were not adopted, and (if previously entered by the corporation) the extent to which the transaction has benefited the corporation, is fair and reasonable as to the corporation, and has not unjustly enriched the interested director(s).

(e) An approval or other response of the Commissioner under Section 10824 of the Corporations Code to a request for an approval of a self-dealing transaction shall not constitute a "ruling" or other response under Section 10826 of the Corporations Code or under any provision of the Act unless it expressly so states.

(f) Any written statement designated as an "approval" by the Commissioner pursuant to this section constitutes an approval only for the purpose of Section 10824 of the Corporations Code and only to the extent that the material facts of and surrounding the transaction prior to, at the time of, and subsequent to the date of the transaction are fully and completely disclosed by the representations set forth in the request and are consistent with any assumptions upon which the statement is based. Any such approval or other response may be rendered inoperative ab initio or modified in writing by the Commissioner when and to the extent that the Commissioner determines that the past, present, or reasonably anticipated future material facts would support a conclusion differing from the conclusion expressed in, presupposed by, or implied by the approval.

NOTE: Authority cited: Section 10824, Corporations Code. Reference: Section 10824, Corporations Code.

1300.826. Request for Ruling on Proposed Action or Article Amendment.

(a) A request voluntarily submitted for a ruling by the Commissioner on a proposed action (including a self-dealing transaction) under Section 10826 of the Corporations Code shall contain the information required by items (2) and (3) of Subsection (b) of Section 1300.824.1 and items (1) and (2) of Subsection (c) of Section 1300.824.1, plus at least the following:

(1) A letter signed on behalf of the Corporation by an authorized director or officer thereof or by or on behalf of a director or officer of the corporation and addressed as indicated in Section 1300.824(b), expressly requesting such a ruling, setting forth a detailed description of the proposed action (including the date and place thereof) and all material facts regarding the proposed action, and expressly stating whether the proposed action is or involves a self-dealing transaction. If the proposed action is or involves a self-dealing transaction, the letter shall include the information required by Section 1300.824.1(b)(1).

(2) If the proposed action is or involves a self-dealing transaction, the information required by items (3) and (4) of Section 1300.824.1(c).

(3) Such additional information as the Commissioner may require. The Commissioner may require, among other things, a signed and dated opinion of counsel admitted to practice law in the State of California, supported by a reasoned discussion of the pertinent facts and authorities, as to whether the proposal, if implemented, would be consistent or inconsistent with the requirements of a charitable trust, and as to such additional issues as the Commissioner may require.

(b) For the purposes of Subsection (a), "material facts" shall include at least the reasons for (and against) the action, the benefit such action will confer upon the corporation, whether the board of directors has approved the action, the criteria used and information considered by the board of directors to evaluate and approve the action, and the details of any studies which have been made of the proposed action.

(c) A request for a ruling by the Commissioner on a proposed article amendment under Section 10826 of the Corporations Code shall contain the information required by items (2) and (3) of Subsection (b) of Section 1300.824.1 and items (1) and (2) of Subsection (c) of Section 1300.824.1 and items (2) and (3) of Subsection (a) of this Section, plus at least the following:

A letter signed on behalf of the corporation by any officer or director thereof and addressed as indicated in Section 1300.824(b), expressly requesting such a ruling, setting forth a copy and a detailed description of the proposed article amendment and all material facts concerning the proposed article amendment, and expressly stating whether the proposed article amendment is or involves a self-dealing transaction and the date that the article amendment is proposed to be adopted. If the proposed article amendment is or involves a self-dealing transaction, the letter shall include the information required by Section 1300.824.1(b)(1).

(d) "Material facts" shall include at least the reasons for (and against) the article amendment, the benefit such amendment will confer upon the corporation, whether the board of directors has approved the amendment, the criteria used and information considered by the board of directors to evaluate and approve the amendment, and the details of any studies which have been made of the proposed amendment.

(e) The Commissioner may respond to requests for a ruling on proposed actions (including self-dealing transactions) and article amendments by issuing to the requesting corporation a written statement expressly pursuant to Section 10826 representing that the Commissioner will or may oppose the proposed action or article amendment, that the Commissioner will not oppose the proposed action or article amendment, or that the Commissioner declines to give a ruling on the proposed action or article amendment. Any such statement of the Commissioner may set forth such additional comments, if any, as the Commissioner may deem appropriate under the circumstances.

(f) A ruling or other response of the Commissioner under Section 10826 of the Corporations Code, whether or not the subject of the request for a ruling is or involves a self-dealing transaction, shall not constitute an "approval" or other response under Section 10824(d) of the Corporations Code or under any provision of the Act unless it expressly so states.

(g) Any written statement designated as a "ruling" by the Commissioner pursuant to this section constitutes a ruling only for the purposes of Section 10826 of the Corporations Code and only to the extent that the material facts of and surrounding the action or article amendment prior to, at the time of, and subsequent to its implementation, are fully and completely disclosed by the representations set forth in the request and are consistent with any assumptions upon which the ruling is based. Any such ruling or other response may be rendered inoperative ab initio or modified in writing by the Commissioner when and to the extent that the Commissioner determines that the past, present, or reasonably anticipated future material facts would support a conclusion differing from the conclusion expressed in, presupposed by, or implied by the ruling.

NOTE: Authority cited: Section 10824, Corporations Code. Reference: Section 10826, Corporations Code.

ASSOCIATION OF CALIFORNIA LIFE INSURANCE COMPANIES

BRAD WENGER
COUNSEL & SECRETARY

1400 K STREET, SUITE 212 SACRAMENTO, CALIFORNIA 95814 (916) 442-3648

October 15, 1984

Sal Bianco, Consultant
Assembly Finance and Insurance Committee
State Capitol, Room 3112
Sacramento, California 95814

Dear Sal:

This is in response to your request for our comments concerning the Assembly Finance and Insurance Committee's consideration of the overlapping jurisdiction of the Department of Insurance and the Department of Corporations. You have also indicated that the "tax" issue is of concern so we will comment on it as well.

I have enclosed a number of documents which are relevant to your inquiry and that, in our view, clearly demonstrate the unfairness of the regulatory and tax system that governs our members, but not such health carriers as Blue Cross, Blue Shield and Kaiser. For purposes of organization, I have labeled the enclosures and will simply summarize their content for your information.

EXHIBIT NO. 1

Mr. Mason's paper does an excellent job of tracing the historical underpinnings of California's current system and we generally endorse its findings and conclusions.

California's split jurisdictional system applies different rules to similarly situated competitors operating in a single marketplace. Besides being illogical and unfair, it can allow unscrupulous operators to hide between regulatory cracks, or avoid regulation totally by claiming to be regulated by the other regulator. By the time jurisdiction is established, the damage has already been done.

Although the Legislature has taken steps to facilitate a more effective regulatory response, (AB 2670, McAlister of 1982), the better and more lasting solution lies in consolidation of regulatory responsibilities in the Department of Insurance. The Department of Insurance is the best equipped regulator because it presently oversees both commercial insurer and service plans, and has more experience in handling insurance matters.

EXHIBIT NO. 2

This exhibit was prepared by the Health Insurance Association of America. It confirms the fact that California is out of step in its method of regulating and taxing service plans.

Virtually all states apply their general health insurance laws to service plans. Most of them (34) apply them generally or in their entirety. Moreover, most states tax service plans for the purpose of raising revenue. Many (17) tax them on the same basis that they do insurers.

EXHIBIT NO. 3

This exhibit presents ACLIC's reasons for supporting a change in the insurance tax. Possible methods of change include:

1 - Relitigating the Garrison decision.

2 - City taxation of service plans.

3 - Legislation to equalize the tax rate or phase down the tax on commercial insurers to a minimum level.

4 - Insurers providing benefits through the tax-exempt "service-plan" method of operation.

We thank you for the opportunity to once again present our views on this important subject. We hope this will add to the committee's understanding of the severe competitive disadvantage that insurers face due to the overlapping jurisdictions of the Department of Insurance and the Department of Corporations, and tax-loophole for service plans.

Sincerely,

Brad Wenger

BW:pp

Enclosures

EXHIBIT NO. 1

California Legislature

Assembly Committee on Finance, Insurance and Commerce

ALISTER McALISTER
CHAIRMAN

STATE CAPITOL BUILDING
ROOM 3112
SACRAMENTO, CALIFORNIA
95814
(916) 445-9160

MEMORANDUM

TO: Members of the Finance, Insurance and Commerce Committee

FROM: Richard K. Mason, Principal Consultant

SUBJECT: Interim hearing on Regulation of Health Care Service Plans, Nonprofit Hospital Service Plans and Health Insurers.

The Finance, Insurance and Commerce Committee will conduct a one-day hearing on the above subject on Thursday, November 13th beginning at 9:30 AM, in Room 4202 of the State Capitol.

The committee is reviewing the regulation of nonprofit hospital service plans, health insurers and health care service plans because these entities are regulated by two separate departments under three separate statutory programs. The fact that they are regulated under different

laws is becoming more important for several reasons. The competition among these entities is very keen and the differences in regulation has led to claims by some licensees that they are operating at a competitive disadvantage because their regulation imposes too many requirements and restrictions. The committee is also reviewing the regulation of health care service plans, nonprofit hospital service plans and health insurers because the distinctions between each are becoming less clear as nonprofit hospital service plans and health insurers get into the health care service plan business through the acquisition of health care service plans known as health maintenance organizations (HMO).

The hearing today will explore how health care service plans, nonprofit hospital service plans and health insurers are regulated, how health insurers and nonprofit hospital service plans are getting into the HMO business, and how the laws might be rewritten to reflect what is actually taking place in the health insurance and health care marketplace. The committee will hear testimony from representatives of the Departments of Corporations and Insurance who will explain how each department regulates its licensees. We will also hear testimony from Mr. Gary Gibson, Chief Executive Officer of Family Health Services (who alleges that licensees of the Department of Corporations

are at a competitive disadvantage with the licensees of the Department of Insurance), representatives of Blue Cross, Blue Shield, Kaiser, Ross-Loos and representatives of health insurers.

The following is a brief background discussion of how health care service plans, nonprofit hospital service plans and health insurers are regulated and the issues we will be reviewing today.

BACKGROUND

Health Care Service Plans
(a.k.a. Health Maintenance Organizations or HMO's)

The first prepaid health plan law was the Knox-Mills Health Plan Act of 1965, which gave the Attorney General responsibility for regulating health care service plans. Knox-Mills regulated those organizations which provided comprehensive health care services for prepaid or periodic charges. Knox-Mills prohibited misrepresentation and required plans to include certain minimum services as well as financial responsibility. Plans were required to register with the Attorney General and to provide him with information regarding membership contracts and copies of advertising. The Attorney General was authorized to issue cease and desist orders, to seek injunctive relief, to appoint receivers and to pursue appropriate remedies

in response to violations. Knox-Mills did not contain provisions establishing quality of care standards, nor provisions for the Attorney General to regulate the marketing activities of health care service plans.

In 1975, the Legislature passed the Knox-Keene Health Care Service Plan Act to replace the Knox-Mills Health Plan Act. Knox-Keene requires health care service plans, like Kaiser and Ross-Loos, to be licensed by the Department of Corporations. The Knox-Keene Act applies to all health care service plans, regardless of whether they are sponsored by private or public organizations. Blue Shield, which is discussed later in this background paper, is licensed as a health care service plan under Knox-Keene, even though it operates more as an insurer than as a health care service plan.

There are 66 health care service plans licensed under the Knox-Keene Act. Thirty-six of these are "full service" plans which provide all of the basic health care services mandated by the Act. The required basic services include physician services, including consultation and referral; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; and emergency health care services, including

ambulance services and out-of-area coverage. Eighteen of the 36 full service plans are federally-qualified health maintenance organizations and 12 of the 36 full service plans contract with the Department of Health Services to provide prepaid health services to Medi-Cal beneficiaries.

Thirty of the 66 licensed health care service plans are "specialized," in that, they only offer health care contracts in one or more particular fields, such as vision care, mental health care or dental care. For example, California Dental Service is licensed under Knox-Keene as a specialized health care service plan.

In addition to requiring that full service health care service plans contain specific basic health care services, Knox-Keene regulates their marketing and advertising and requires the Department of Corporations to conduct financial examinations and quality of health care field examinations. Knox-Keene also established enforcement procedures involving administrative, civil and criminal sanctions.

The Department of Corporations was authorized on January 1, 1976, to begin drafting regulations for administering the Knox-Keene Act, and the Act, as a whole, became operative on July 1, 1976. The health care service plans which had registered with the Attorney General under

the Knox-Mills Health Plan Act were permitted to continue operation under that Act until their license applications were granted or denied under the Knox-Keene Act. The Department of Corporations has found the task of licensing health care service plans to be more arduous and time-consuming than anticipated. Representatives of the Department will be able to bring the committee up to date on the status of the Knox-Keene Act.

Nonprofit Hospital Service Plans.

Nonprofit hospital service plans, such as Blue Cross, are regulated by the Department of Insurance under Chapter 11a of the Insurance Code. Blue Cross is organized as a nonprofit insurance corporations. Under the provisions of its service plans, it will pay a certain percentage of physician bills and maintains contracts with hospitals to provide hospital care to Blue Cross subscribers. Nonprofit hospital service plans are required to maintain reserves as specified by Section 11507 of the Insurance Code and submit annual reports to the Department of Insurance for review. Nonprofit hospital service plans are not providers of health care services. Therefore, they are not subject to quality of care reviews or required to submit advertising to the Department of Insurance for review. However, because

nonprofit hospital service plans are insurers, they are regulated by the Department of Insurance as insurers. This means that their contracts are reviewed by the Department as well as their reserves and their handling of claims.

Commercial Health Insurers.

Commercial health insurance companies, such as Cal-West, Metropolitan, etc., receive periodic payments (premiums) and indemnify their policyholders for a portion of their health care costs. Commercial health insurers do not provide or arrange for the provision of health services. Commercial health insurance companies are regulated by the Department of Insurance under various provisions of the Insurance Code. Generally, the Department examines these companies to make sure that they maintain required reserves, offer policies with meaningful benefits and process claims in a responsible manner.

The Department of Insurance does not conduct quality of care examinations of health insurers because insurers do not provide or arrange for health care services. Health insurers are required by law to maintain larger reserves than nonprofit hospital service plans and to pay an annual 2.35 percent tax on gross premiums.

Self-Insured Health Plans.

There are two additional players in the health insurance and health care service plan arena known as private self-insured health plans and local agency self-insured health plans (also know as employee welfare benefit plans). The Department of Corporations maintains that these entities are subject to regulation by the Department under the Knox-Keene Act. However, the courts have held that the Knox-Keene Act is preempted by the federal Employee Retirement Income and Security Act (ERISA) from regulating employee welfare benefit plans. The Department believes that the ERISA preemption limits the ability of the state to regulate the delivery of health care services to the above employee groups. However, the Department would only be able to regulate self-insured health plans under the Knox-Keene Act if Congress amended ERISA to remove the preemption.

Regulation and its Effects.

As discussed above, the regulation of health insurers, health care service plans and nonprofit hospital service plans is anything but uniform. Elements of the health insurance and health care service plan industries would argue, however, that uniformity is important because competition for policyholders and subscribers is very strong

and the differences in existing laws and regulations generates advantages and disadvantages to certain licensees. For example, Mr. Gibson of Family Health Services, would argue that Knox-Keene licensees operate at a competitive disadvantage with nonprofit hospital service plans and indemnity insurers because Knox-Keene licensees are required to offer basic health care services. Health insurers and nonprofit hospital service plans have no requirement to cover the basic services required of health care service plans. However, provisions of the Insurance Code state that if an insurance policy or nonprofit hospital service plan includes a certain coverage, that coverage must satisfy certain standards. For example, plans and policies which cover mastectomy surgery must also cover prosthetic devices or reconstruction surgery incidental to mastectomies.

Mr. Gibson, and other Knox-Keene licensees would also argue that the review of quality of care and advertising by the Department of Corporations is not imposed by the Department of Insurance upon health insurers or nonprofit hospital service plans. This is true, however, nonprofit hospital service plans and health insurers do not provide or arrange for the provision of health care services. Their policies and contracts, however, are reviewed by the Department of Insurance.

Commercial health insurers believe that they operate at a competitive disadvantage with nonprofit hospital service plans because they are required to pay a 2.35 percent premium tax. This is not imposed on nonprofit hospital service plans. Commercial insurers must also maintain larger reserves than nonprofit hospital service plans.

The Blue Shield Anomaly

The regulation and requirements of health care service plans, nonprofit hospital service plans and commercial health insurers in California is not uniform, as discussed above. A curiosity of existing regulation is that Blue Shield is regulated under Knox-Keene as a health care service plan while it is actually an insurer that should be regulated by the Department of Insurance. In California Physicians' Service v. Garrison, 28 Cal 2nd 790 (1946), it was determined that Blue Shield was not engaged in the insurance business and was not subject to the regulatory laws governing insurance. However, it was subject to regulation by the Attorney General under Knox-Mills.

Although Blue Shield had been categorized as other than an indemnity company in 1946, by 1973 it appeared to be making payments to nonparticipating doctors or subscribers for services of nonparticipating doctors that ranged from

between 64 to 79 percent of its standard business. In 1974, the Attorney General and Department of Insurance conducted a joint investigation, in part, to determine the extent and scope of the indemnity nature of Blue Shield's business. At the conclusion of the joint investigation, the Department of Insurance determined that in the 30 years that elapsed since the Garrison case in 1946, Blue Shield's operations changed to the point where the bulk of its business was concerned with indemnity rather than the provision of health care services. Before any action could be initiated to license Blue Shield as an insurer, the Knox-Keene Act became operative and Blue Shield was placed under its provisions.

Knox-Keene defined "health care service plan" to be an entity which allows reimbursements (indemnification) to subscribers, as long as the reimbursements do not constitute a substantial part of the health care service plan's expenditures. The percentage of payments made by Blue Shield for non-plan doctors' expenses clearly exceeded the statutory prohibition under Knox-Keene against a plan providing substantial indemnification. Blue Shield was given a health care service plan license by the Department of Corporations on the condition that it reduce its level of indemnification within three years.

Blue Shield has been unable to satisfy this requirement. Therefore, in 1980, it sponsored AB 2341 (Knox) to change the definition of "health care service plan" to allow reimbursement to subscribers (indemnification) without limiting the portion of health care service plan expenditures which in fact are indemnifications. When AB 2341 was heard by the Assembly Health Committee on March 24, 1980, the staff analysis made the following comment:

> The Knox-Keene Act reinforced a 35-year distinction that existed in California between health care plans that primarily provide or arrange for services and thereby relieve the subscriber of risk, and health care plans that reimburse providers or subscribers for the cost of medical services incurred by subscribers and thereby shift risk to the subscriber. This bill, by removing the prohibition against substantial indemnification, removes the distinction and potentially extends the Knox-Keene Act to health care plans, which may be essentially indemnity companies but because of a small percentage of payments for contracted services, would qualify as a health care service plan and escape regulation as an indemnity company by the Insurance Commissioner.

AB 2341 was signed by the Governor on July 17, 1980, and is now Chapter 628, Statutes of 1980. Consequently, Blue Shield will be able to continue doing business as an insurer, but be licensed under Knox-Keene as a health care service plan.

Future Trends.

There are signs that the existing regulation of health care service plans, nonprofit hospital service plans and health insurers will become more illogical as the distinctions between each becomes less obvious because of the increased popularity of HMO's and the rush of nonprofit hospital service plans and health insurers to get into the HMO business. According to Business Week (October 27, 1980, p. 108):

> ...the HMO has now begun to win warm support from employers, who increasingly regard it as a way of providing high-quality employee health care at lower cost than under conventional health care insurance--or at least, as providing the competition that will slow cost increases.

As a result of employer approval and provisions of the federal Health Maintenance Organization Act of 1973, HMO's will continue to increase in number throughout the country. For example, Kaiser joined with Prudential Insurance Company in June 1979 to form the Kaiser/Prudential Health Plan in Dallas, Texas. Prudential now has HMOs in Houston, Dallas, Austin and Nashville, and will open two more in April 1981 in Atlanta and Oklahoma City. Insurance Company of North America (INA) now owns or operates seven HMOs with a total enrollment of 430,000 members, according to Group Health News. INA is now the owner of Ross-Loos, which is a health care service plan licensed under Knox-Keene.

Blue Cross and Blue Shield (they are joint companies in some states) provide management and marketing services to 30 HMOs, and 33 Blue Cross-Blue Shield plans operate 39 HMOs. Blue Cross has begun two HMOs in California which will be regulated under Chapter 11a of the Insurance Code rather than under Knox-Keene. We are advised that the Catholic Hospitals Association will be entering the HMO business very shortly. These plans also will be regulated under Chapter 11a rather than under Knox-Keene.

SUMMARY

This background paper has attempted to demonstrate that the regulation of health care service plans, nonprofit hospital service plans and health insurers is not uniform even though these entities are highly competitive. Existing regulation generates competitive advantages and disadvantages, though licensees will disagree over their severity. Existing laws do not reflect that the distinctions between health care service plans, nonprofit hospital service plans and health insurers are disappearing due to the entry of nonprofit hospital service plans and health insurers into the HMO business.

In order to restore some logic to the regulation of these entities and eliminate competitive disadvantages,

Blue Shield, because it is an insurer, should be regulated by the Department of Insurance under provisions of the Insurance Code rather than by the Department of Corporations under Knox-Keene. Chapter 11a, Knox-Keene and relevant sections of the Insurance Code should be repealed and new statutory provisions that would include health care service plans, nonprofit hospital service plans and health insurers should be drafted. These provisions should be administered by one department, such as the Department of Insurance. Quality of care reviews of HMOs could be performed by trained professionals under contract with the Department or by personnel in the Department of Health Services. One law administered by one department would eliminate any competitive advantages or disadvantages and recognize the changes taking place in the marketplace.

It is suggested that the Department of Insurance be the regulating agency because health insurers and nonprofit hospital service plans, such as Blue Cross, are in the insurance business. In reality, Blue Cross is not an eleemosynary organization, but is a mutual insurer. Chapter 11a does not reflect this fact. Health care service plans are a variation of insurance and they could effectively be regulated by the Department of Insurance. Currently, health care service plans are regulated by the state Departments of Insurance in Arizona, Idaho, Indiana, Kansas,

Kentucky, Massachusetts, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, Oklahoma, Texas, Washington and West Virginia. In Arkansas, Colorado, Florida, Georgia, Illinois, Iowa, Maine, Maryland, North Dakota, Ohio, South Dakota and Utah the state Departments of Insurance are the primary regulators and the state Health Departments are responsible for reviewing the quality of health care. In Pennsylvania, South Carolina and Tennessee the state Departments of Insurance and Health jointly regulate health care service plans.

ASSOCIATION OF CALIFORNIA LIFE INSURANCE COMPANIES

EXHIBIT NO. 2

BRADLEY E. WENGER
SECRETARY & ASSISTANT COUNSEL

1400 K STREET, SUITE 212 SACRAMENTO, CALIFORNIA 95814 (916) 442-3648

April 19, 1983

Clifford Allenby, Assistant Director
Department of Finance
State Capitol, Room 1145
Sacramento, California 95814

Dear Cliff:

The enclosed was prepared by the Health Insurance Assocation of America.

In my opinion it clearly and concisely compares State tax and regulatory treatment of Blue Cross and Blue Shield.

Sincerely,

Bradley E. Wenger

BEW:pp

Enclosure

cc: Bob Walters

BLUE CROSS/BLUE SHIELD
REGULATORY ANALYSIS

JULY 1982

The purpose of this analysis is to identify very basic and fundamental areas of statutory and regulatory standards applicable to health insurers and to quantify the degree to which nonprofit hospital and medical service plans (Blue Cross/Blue Shield) must also meet these standards. In this way it is the function of this analysis to provide a comparison through which the competitive advantage on the part of nonprofit hospital and medical service plan corporations over insurers can be readily made apparent.

The analysis identifies seven basic areas; namely, the nature of the corporate structure of the service plan corporations, their reserve and surplus requirements, if any, the degree to which they are subject to premium taxation and the general substantive laws applicable to health insurance, whether and to what extent they are subject to rate and contract review or approval, and finally, an attempt is made to indicate in a general manner the amount of any hospital discount that may exist. Most of the information in these areas is self-explanatory, however, further definition of some of the chart material and references is needed.

In the column "Effect of Insurance Laws" we have used indicators "0, 1, 2 and 3" to indicate the degree to which nonprofit service plan corporations are subject to the same substantive statutory requirements as insurers. By "substantive law" we mean statutory requirements of a substantive nature such as minimum benefit standards, mandated coverages of whatever kind, conversion mandates, and the plethora of general restrictions on underwriting, exclusions, definitions, and kinds of permitted coverages. These indicators have assigned to them the following meanings:

0 -- Generally exempt from substantive health insurance laws
1 -- Limited application of substantive health insurance to nonprofit service plan corporations
2 -- General application of many substantive health insurance laws to nonprofit service plan corporations
3 -- All substantive health insurance laws applicable to nonprofit service plan corporations

The indicators were assigned by each staff lawyer based on his/her personal expertise in dealing with legislation in each state and general knowledge of applicable laws and regulations. This approach, it was felt, would be far more accurate than the traditional approach of identifying mechanically whether nonprofit service plan corporations operate under a separate (and in varying degrees, exclusive) chapter of the code, and if so, to what extent has "companion legislation" been incorporated in such chapters.

The "Rate & Contract Review" column indicates as to each of the four categories the following identifiers:

O -- No specific requirements for filing or approval
F -- Only filing required of forms or rates
A -- Approval required of forms or rates

Finally, the last column attempts to identify, in terms of percentage ranges, the extent of hospital discounts that have been secured by nonprofit service plan corporations. This information was derived from several sources: American Hospital Association; HIAA Consumer and Professional Relations Department information and general knowledge, none of which can be taken independently as completely verifiable. Even in the case of the American Hospital Association data, which might be assumed to be the most authoritative, the existence of a discount in some states simply is not known, and in others the discounts can only be stated in terms of a "high, average and low", and these indicators often apply only to specific hospitals or specific areas within a state. For these reasons we have attempted to simplify the available data by indicating an average range of discounts in increments of 5 percentage points. In states indicating a "0" there is either no discount or information establishing one does not exist.

Health Insurance Association of America
332 South Michigan Avenue
Chicago, Illinois 60604

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Alabama §10-4-112	Not for profit Corporation	Unearned premium - 0 Claims - $3,000 to $20,000 Deposit with treasurer	0	1% premium tax (same as domestic insurers	2	Subscriber rates - A Subscriber contracts - F Provider rates - 0 Provider contracts - 0	10 - 15%
Alaska §21.87.200	Nonprofit corporation	Unearned premiums & claims, unspecified amt. Retained by company	$50,000 to $100,000	6% of gross premiums, less claims paid (domestic insurers 1% premium tax) (foreign insurers 3% premium tax)	2	Subscriber rates - F Subscriber contracts - A Provider rates - A Provider contracts - A	0
Arizona §20-828	Nonprofit & benevolent institution	Unearned premiums & claims - $200,000 plus 2% of subscriptions Deposit with State Treasurer	0	1% premium tax; exempt from school, real estate & personal property taxes. (domestic insurers 1% premium tax) (foreign insurers 2% premium tax)	2	Subscriber rates - F Subscriber contracts - A Provider Rates - 0 Provider contracts - F	0
Arkansas §66-4906	Nonprofit corporation	Unearned premium - 0 Claims - $15,000 to $50,000 Deposit with Commissioner	0	1% premium tax; exempt from school, real estate & tangible personal property taxes. (domestic insurers w/o home office 2 1/2% premium tax) (foreign insurers 2% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0
California §11507	Nonprofit, charitable & benevolent institution	Unearned premium - 0 Claims - $10,000 to $20,000 Retained by company	50% of minimum paid in capital	Exempt. Pays only real estate & office equipment tax. (domestic insurers 2.35% premium tax) (foreign insurers 2.35% premium tax)	1	Subscriber rates - F Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0 - 5%
Colorado §10-16-113	Corporation to promote availability of hospital services on voluntary nonprofit basis.	Unearned premium & claims combined. A minimum of $50,000 in one account. Deposit with Insurance Commissioner.	0	Exempt. (domestic insurers 1% premium tax) (foreign insurers 2 1/4% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0 - 5%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Connecticut §33-157	Nonprofit corporation	Unearned premium & claims, unspecified amt. Retained by company	0	2% tax on net premiums; exempt from state & local taxes. (domestic insurers 2% premium tax) (foreign insurers 2% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0 - 5%
Delaware §6302	Nonprofit corporation	0	0	Not taxed. (domestic insurers 2% premium tax) (foreign insurers 2% premium tax)	1	Subscriber rates - F Subscriber contracts - F Provider rates - F Provider contracts - F	0
District of Columbia §35-202	Nonprofit corporation	Subject to regs. as an insurance company. $25,000 of capital	0	Exempt (Foreign & domestic pay 2% premium tax)	0	Subscriber rates - 0 Subscriber contracts - 0 Provider rates - 0 Provider contracts - 0	5 - 10%
Florida §624.407	Benevolent & charitable association	0	$500,000 formation requirement	Exempt (domestic insurers pay no premium tax) (foreign insurers 2% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	0
Georgia §56-1819	Nonprofit corporation, treated as a chartiable & benevolent institution.	Unearned premium & claims. Accumulate to $75,000. Retained by Corp.	0	Exempt from all taxes. (2 1/4% premium tax on foreign & domestic insurers, but 1 1/4% tax if 1/4 of assets are in property taxable by state.)	1	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	0
Hawaii §433-7	Nonprofit corporation, treated as a charitable & benevolent institution.	Unearned premium - 0 Claims reserve of unspecified amt. Deposit with Insurance Department	0	Exempt (domestic life insurers 1.918% premium tax) (other domestic 2.9647% premium tax) (foreign life 3.197% premium tax) (other foreign 4.2824% premium tax)	1	Subscriber rates - 0 Subscriber contracts - 0 Provider rates - 0 Provider contracts - 0	0

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Idaho §41-3421	Nonprofit prepaid health care service organization	Unearned premium reserve & a claims reserve of unspecified amt. each retained by insurance company	$50,000 to $100,000	Taxed at 1¢ per subscription per month; exempt from all other taxes but real estate & property tax. (foreign & domestic insurers 3% premium tax) (domestic tax 1% if it maintains 25% of its assets in property taxable by state)	2	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	0
Illinois Ch. 32§554	Nonprofit, charitable & benevolent institutions	0	Initial working capital of $1,500,000 minimum surplus $1,000,000	Hospital Service Corporations exempt from all taxes but real estate & office equipment. Medical Service Corporation exempt from all taxes. (domestic insurers pay no premium tax) (foreign insurers 2% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	5 - 10%
Indiana §27-8-7-5	Organized as a mutual corporation	Post surety bond & possess cash or securities the greater of $100,000 or 2 1/2% premium	(Treated as mutual insurer)	Taxed as a domestic mutual company. Domestics may elect 2% premium tax or 3% corporate & 4% supplemental tax. Foreign insurers pay 2% premium tax	3	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
Iowa §514.1	Nonprofit corporation	0	0	2% premium tax (same tax on foreign & domestic companies)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - A	0 - 5%
Kansas §40-1809	Nonprofit corporation	0	0	Taxed as insurance companies, 1% premium tax if domestic; 2% premium tax if foreign	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0 - 5%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Kentucky §304.32-001	Nonprofit corporation	Minimum of $50,000, retained by company. Formula 5% of income < $2,000,000 plus 2 1/2% of income $2,000,000 to $10,000,000 plus 1% of income > $10,000,000	0	Pay a 2¢ per contract fee. (Foreign & domestic insurers pay 2% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
Louisiana §22:211	Charitable & benevolent institution	0	Initial minimum surplus $300,000 for mutual health & accident. Domestic stock health & accident $100,000 paid in capital & $200,000 minimum surplus	Exempt but subject to real estate & property taxes.	2 (N)	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
Maine 24§2301	Charitable & benevolent organization	0	0	Exempt from all taxes (domestic insurers 1% premium tax) (foreign insurers 2% premium tax)	2 (N)	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	10 - 15%
Maryland 48§355	Nonprofit service plan	3% of prior years earnings retained by company unencumbered assets of $25,000	Working capital ≥ $100,000 to start	Exempt (Foreign & domestic insurers pay 2% premium tax)	2 (N)	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0 - 5%
Massachusetts Ch. 176A§24	Charitable & benevolent corporation	special reserve fund for contingencies with very complex formula	0	Exempt from all state & local taxes (foreign & domestic insurers pay 2% premium tax)	2 (N)	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	10 - 15%
Michigan 550.1204	Charitable & benevolent institution	Contingency reserve at 11.5% of prior years claims or expenses, whichever is more. Retained by company	Working capital of $500,000 to start	Exempt from all taxation. (domestic pay no premium tax) (foreign insurers pay 2% premium tax)	0	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	15 - 20%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Minnesota §62C.09	Nonprofit corporation	0	$400,000 initial surplus, & during operations need ≥ $300,000 or 16 2/3% of prior years claims & admin. expenses as surplus	Exempt (Foreign & domestic pay 2% premium tax)	2 (14)	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0
Mississippi §83-41-5, 107	Charitable & benevolent institution	Contingency fund of $5,000 at start, increased to $75,000 or 55% of net premium income, retained by company.	Capital stock ≥ $10,000. Deposit with State Treasurer. $1,000 - $10,000 in securities	Taxed as insurance company. Domestic insurers pay 1 1/2% premium tax with up to a $20,000 credit for ad valorem real estate tax (foreign insurers pay 3% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0 - 5%
Missouri §354.075	Nonprofit corporation	Operating reserves of 2 months payments & expenses, set aside by company	Paid in capital or guarantee fund of ≥ $150,000	Exempt (Foreign & domestic insurers pay 2% premium tax)	2 (15)	Subscriber rates - 0 Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0 - 5%
Montana §33-30-201	Nonprofit prepaid plan	Reserves the lesser of $500,000 or 1 months average income, retained by company	0	Exempt (Foreign & domestic insurers pay 2 3/4% premium tax)	2 (16)	Subscriber rates - 0 Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
Nebraska §21-1514	Nonprofit corporation	Reserves as deemed adequate by the Insurance Department	Working capital as deemed adequate by Insurance Dept. Organized under general corp. laws	Pay 0.6% premium tax (same as domestic insurers) (foreign insurers 2% premium tax)	2 (17)	Subscriber rates - A Subscriber contracts - A Provider rates - F Provider contracts - F	0 - 5%
Nevada §695B.140	Nonprofit corporation	To start need $10,000 to $20,000 based on number of subscribers	0	2% premium tax (same as foreign & domestic insurers)	2 (18)	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0
New Hampshire	Not for profit corporation	0	0	Exempt; pay a $200 license fee (Foreign & domestic pay 2% premium tax)	2 (19)	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	0 - 5%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
New Jersey §17:48A-4	Charitable & benevolent institution	0	$5,000 for medical service corporation to start business. None for hospital service corporation	Exempt; pay fee of 2¢ per subscriber. (Foreign & domestic pay 2% premium tax, except group A&H which pays 1%)	2	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	15 - 20%
New Mexico §59-19-6	Nonprofit corporation	Reserves as required by Insurance Commissioner (no rule has been promulgated) Escrow in first year to insure return of premiums if no license granted	0	Premium tax 3/4% if 40% of assets invested in New Mexico, otherwise taxed as insurance company. (Foreign & domestic pay 2 1/2% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
New York §256	Nonprofit indemnity corporations	Increase by 21% of previous years net premium income. Maximum reserve 5% of net premium income of calendar year, retained by company.	0	Exempt from all taxes	2	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	25 - 30%
North Carolina §57-8	Nonprofit corporation	0	Contingent surplus of 3 times average monthly claims accumulated with 4% of first $200,000	1/3 of 1% of premiums in lieu of all other state taxes. (Domestic insurers pay from 1% to 1.6% premium tax) (Foreign insurers pay from 2 1/2% to 4% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - A	0
North Dakota	Nonprofit corporation	0	0	Exempt (domestic insurers pay no premium tax) (foreign insurers pay 2 1/2% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - A	0 - 5%
Ohio §1737.14, .20	Nonprofit corporation	Health care & medical care corps. must maintain an unearned premium reserve of unspecified amount.	0	Taxed as domestic (domestic insurers 6/10 of 1% of net worth or 2 1/2% premium tax, whichever is less.) (foreign insurers pay 2.5% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - A	5 - 10%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Oklahoma §2604	Charitable & benevolent corporation	Deposit with State Treasurer $15,000 plus 2% of gross premiums until deposit totals $25,000	0	Exempt from all but real estate & personal property taxes (domestic exempt) (foreign insurers pay 4% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - A	0
Oregon §750.045	Nonprofit corporation	$5,000 surety bond required unless 75% of assets are invested in health service assets	Surplus of $25,000 or 50% of average monthly claims of preceding 12 months limited to $500,000 maximum	Exempt (domestic insurers exempt) (foreign insurers pay 2 1/4% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
Pennsylvania Ch. 4 §6101	Charitable & benevolent institutions	0	0	Exempt from all taxation (foreign & domestic pay 2% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - A	20 - 25%
Puerto Rico Title 6, Ch. 3 §41-55	Nonprofit corporation	Reserve for contingencies 4% of prior year's fees, accumulated by company to equal 35% of prior year's claims.	Working capital of $5,000 to start	Exempt (domestic insurers with home office exempt) (foreign insurers pay 4% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - F Provider contracts - F	5 - 10%
Rhode Island §27-19-1	Charitable corporation	0	0	Exempt (foreign & domestic pay 2% premium tax)	2	Subscriber rates - A Subscriber contracts - 0 Provider rates - A Provider contracts - 0	5 - 10%
South Carolina §38-35-10	Licensed as a mutual insurance company	Operates as a mutual insurance company	0	2% premium tax (same as domestic insurers) (foreign insurers pay 3% premium tax)	3	Same as for insurance companies	0
South Dakota §58-38-1	Nonprofit corporation	0	0	Taxed as insurance company (domestic 2 1/2% premium tax with substantial credits allowed for property tax) (foreign insurers pay 2 1/2% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - F	5 - 10%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Tennessee §56-27-112	Not for profit corporation	Accumulate reserves of 2 1/2% of premium income up to $75,000 or 55% of annual premium income, whichever is greater.	Working capital $2,500 to start	1 3/4% (same as domestic life, A&H) (foreign & other domestic pay 2%)	2	Subscriber rates - A Subscriber contracts - A Provider rates - F Provider contracts - F	0 - 5%
Texas Art. 20.03, .15	Nonprofit corporation	$2,000 deposit with State Treasurer	Minimum surplus of $100,000	1.1% (same as domestic life, A&H insurers) (foreign insurers pay 3.3% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - A	0
Utah §31-37-14	Nonprofit corporation	Must deposit with insurance commissioner the lesser of a) net reserves for losses; b) 30% of gross premium income; c) $1,000,000	0	2 1/4% (same as foreign & domestic)	2	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0
Vermont §8-4511	Nonprofit corporation	0	0	Exempt from all taxes (foreign & domestic pay 2%)	2	Subscriber rates - A Subscriber contracts - F Provider rates - 0 Provider contracts - 0	0 - 5%
Virginia §38.1-810	Nonprofit nonstock corporation	0	0	1/10 of 1% (foreign & domestic pay 2 3/4% premium tax)	1	Subscriber rates - F Subscriber contracts - A Provider rates - 0 Provider contracts - 0	5 - 10%
Washington §48.44.030	Nonprofit corporation	The greater of a $50,000 surety bond or 1/12 of total income of preceding year, limited to $50,000 maximum, retained by company	0	Exempt (domestic insurers 1% premium tax) (foreign insurers pay 2% premium tax)	2	Subscriber rates - 0 Subscriber contracts - F Provider rates - 0 Provider contracts - F	0 - 5%
West Virginia §33-25-7, 8(e)	Nonprofit corporation	Reserves greater than one month's average obligations & less than 3 months average obligations, retained by company	Working capital sufficient to pay operating expenses prior to licensing	Exempt from all taxes (foreign & domestic pay 3% premium tax)	2	Subscriber rates - A Subscriber contracts - A Provider rates - A Provider contracts - 0	0 - 5%

State	Status	Reserve Requirements	Surplus Requirements	Premium Tax	*Effect of Ins. Laws	**Rate & Contract Review	BC/BS Hosp. Discount
Wisconsin §613.19	Nonprofit corporation	0	Not less than $50,000 nor more than $2,000,000	Exempt (foreign & domestic pay 2% premium tax)	1	Subscriber rates - A Subscriber contracts - A Provider rates - 0 Provider contracts - 0	0 - 5%
Wyoming §26-3-112	Deemed to be transacting insurance	Subject to regulation as an insurance company	0	1 1/2% (same as domestic) (foreign insurers pay 2 1/2% premium tax)	3	Same as insurance companies	0

EXHIBIT NO. 3

STATEMENT BY LEWIS KELLER CONCERNING PREMIUM TAXATION OF HEALTH CARE SERVICE PLANS AND NONPROFIT HOSPITAL SERVICE PLANS

MEETING OF THE ADVISORY COMMISSION ON HEALTH AND ACCIDENT INSURANCE
AUGUST 30, 1983

MR. CHAIRMAN AND MEMBERS OF THE COMMISSION, THE CALIFORNIA CONSTITUTION PROVIDES FOR A DIRECT LEVY OF 2.35% ON ALL PREMIUMS COLLECTED BY "INSURERS" DOING BUSINESS IN CALIFORNIA. THIS TAX HAS BEEN HELD TO BE SELF-EXECUTING, AND CAN BE CHANGED BY THE LEGISLATURE ONLY BY A 2/3RDS VOTE TO INCREASE OR DECREASE THE BASIC RATE. FOR EXAMPLE, THE LEGISLATURE, IN 1982, ACCELERATED THE COLLECTION OF PREMIUM TAX AND REDUCED THE RATE FROM 2.35% TO 2.33%.

IN THE 1930'S THE CALIFORNIA PHYSICIANS SERVICE (BLUE SHIELD) STARTED OFFERING HEALTH CARE COVERAGE FOR A PRESCRIBED GROUP OR INDIVIDUAL/FOR A PERIODIC SUBSCRIBER CHARGE. THE INSURANCE COMMISSIONER, BELIEVING THIS PLAN OF COVERAGE TO BE INSURANCE, INSTITUTED AN ACTION TO REQUIRE THE C.P.S. TO BE REGULATED AS AN INSURER BY THE DEPARTMENT OF INSURANCE. THIS EFFORT WAS RESISTED. IN 1940 THE SUPREME COURT IN CALIFORNIA PHYSICIANS SERVICE V. GARRISON HELD THAT C.P.S. WAS NOT "AN INSURER" WITHIN THE MEANING OF THE APPLICABLE CONSTITUTIONAL AND STATUTORY DEFINITIONS AND TESTS. THE COURT REASONED THAT THE C.P.S. CONTRACTS PROVIDED FOR "SERVICES" RATHER THAN "INDEMNITY." ON THIS SAME LINE OF REASONING THE CONCLUSION WAS REACHED BY THE TAXING AUTHORITIES THAT SINCE C.P.S. WAS NOT REGULATED AS AN INSURER, IT WAS NOT TAXABLE AS AN INSURER. THE GARRISON DECISION THUS OPENED A GAPING LOOPHOLE IN THE CALIFORNIA TAX STRUCTURE.

AS THE YEARS PASSED, WITH THE TAX LOOPHOLE AVAILABLE, SERVICE PLANS PROLIFERATED. THEY DEVELOPED PRIMARILY INTO TWO DISTINGUISHABLE TYPES. FIRST, WERE THOSE OPERATING ON A STATEWIDE BASIS WITH CONTRACTS RESEMBLING THOSE OF INDEMNITY INSURERS. SECOND, WERE THOSE CONTRACTS WRITTEN ON A CAPITATION BASIS, WHICH WERE ESSENTIALLY HEALTH MAINTENANCE ORGANIZATIONS (HMO'S), IN WHICH THE PROVIDERS ACCEPTED FULL RESPONSIBILITY FOR PROVIDING THE SERVICE AND THEREBY ASSUMED THE RISK THAT THEIR NET INCOMES MIGHT BE LOWERED BY ADVERSE EXPERIENCE.

THE FACT THAT INSURERS WERE COMPETING FOR THE SALE OF HEALTH CARE COVERAGE ON A DIRECT BASIS WITH THE SERVICE PLANS BUT WERE COMPELLED TO ADD AN ADDITIONAL 2.35% STATE TAX TO THEIR TOTAL COSTS RESULTED IN A CLEAR AND OBVIOUS MARKETPLACE INEQUITY.

OUR ASSOCIATION, AS EARLY AS 1963, RECOGNIZED THIS INEQUITY. THAT YEAR WE SPONSORED AB 2934 (FLUORNOY), WHICH SOUGHT TO PHASE THE PREMIUM TAX RATE ON HEALTH INSURANCE DOWN TO A VERY LOW RATE WHICH WOULD, IN EFFECT, PROVIDE TAX EQUITY BETWEEN SERVICE PLANS AND INSURERS. THIS BILL FAILED PASSAGE WHEN THE LOSS OF STATE REVENUE WAS NOTED IN THE COMMITTEE ANALYSIS. THE ONLY REPLACEMENT REVENUE DISCUSSED AS AN ALTERNATIVE WAS TO IMPOSE THE PREMIUMS TAX ON THE SERVICE PLANS. PREDICTABLY, THE SERVICE PLANS OBJECTED AND THE BILL DIED.

SIMILAR BILLS HAVE SINCE BEEN CONSIDERED AT VARIOUS TIMES IN RECENT LEGISLATIVE HISTORY. THE MOST RECENT WAS AB 3537 (ROBINSON) OF 1982 WHICH PROPOSED PHASING IN A PREMIUM TAX ON SERVICE PLANS AND PHASING DOWN THE TAX ON HEALTH INSURERS TO A UNIFORM RATE OF 2.0%. THIS EFFORT ALSO FAILED. EVEN THIS YEAR, SOME SERIOUS DISCUSSIONS HAVE BEEN HELD CONCERNING THIS POTENTIAL SOURCE OF REVENUE.

FROM THE STANDPOINT OF OUR ASSOCIATION'S MEMBER COMPANIES, THE NEED FOR EQUALIZATION OF THIS TAX BURDEN IS GREATER THAN EVER. THIS IS BECAUSE OF INCREASINGLY SEVERE COMPETITION FOR HEALTH INSURANCE DOLLARS. EQUALIZATION, AT LEAST THEORETICALLY, CAN BE OBTAINED IN FOUR DIFFERENT WAYS.

ONE WAY WOULD BE A TEST CASE IN THE CALIFORNIA SUPREME COURT OF THE HOLDING IN THE GARRISON CASE, REVIEWING COVERAGE CONTRACTS CURRENTLY IN USE BY CALIFORNIA'S MAJOR SERVICE PLANS. THE COURT COULD EASILY FIND A FACTUAL BASIS FOR CONCLUDING THAT BLUE CROSS, BLUE SHIELD AND THE OTHER STATEWIDE INDEMNITY-TYPE SERVICE PLANS ARE IN FACT DOING AN INSURANCE BUSINESS AND SUBJECT TO THE STATE'S CONSTITUTIONALLY-IMPOSED GROSS PREMIUMS TAX.

ANOTHER WAY WOULD BE FOR CALIFORNIA'S CHARTERED CITIES AND GENERAL LAW CITIES TO IMPOSE ON ALL PREMIUM TAX-EXEMPT HEALTH CARE AND HOSPITAL SERVICE PLANS DOING BUSINESS WITHIN THEIR LIMITS A GROSS PREMIUMS TAX BASED ON 2.35% OF THEIR SUBSCRIBER INCOME. THE LEGISLATIVE COUNSEL HAS CONCLUDED IN A WRITTEN OPINION THAT THIS WOULD BE A VALID MUNICIPAL TAX. THIS WOULD PROVIDE A VALUABLE SOURCE OF MUCH-NEEDED INCOME FOR LOCAL GOVERNMENT WHILE EQUALIZING THE EXISTING UNFAIR COMPETITIVE SITUATION.

A THIRD WAY WOULD BE FOR THE LEGISLATURE TO ACT. THE LEGISLATURE COULD TAX THE SERVICE PLANS AT THE SAME RATE AS INSURERS, PHASE THE TAX ON INSURERS DOWN TO A MINIMUM LEVEL, OR TAX BOTH EQUALLY AT SOME INTERMEDIATE RATE. CURRENTLY, A GROSS PREMIUMS TAX AT THE CURRENT RATE ON ALL SERVICE PLAN INCOME IN CALIFORNIA WOULD PRODUCE APPROXIMATELY THE SAME AS THAT CURRENTLY BEING PRODUCED BY THE PREMIUM TAX ON INSURER'S PREMIUMS; I.E., $100 MILLION DOLLARS ANNUALLY. THIS IS BASED ON THE ASSUMPTION THAT THE TWO

COMPETING FORMS OF PROVIDING HEALTH CARE COVERAGE ARE NOW GENERATING APPROXIMATELY THE SAME NUMBER OF DOLLARS IN INCOME, WHETHER CALLED "PREMIUMS" OR "SUBSCRIBER CHARGES." THE LEGISLATURE, OF COURSE, WOULD HAVE THE POWER TO EQUALIZE THE TAX BETWEEN THE TWO FORMS OF HEALTH CARE COVERAGE IN ANY MANNER DEEMED BY IT TO BE SOUND PUBLIC POLICY.

THE FOURTH METHOD OF OBTAINING EQUALITY IS CURRENTLY IN PROCESS. ALTHOUGH IT HAS BARELY STARTED, IT DOES OFFER A FEASIBLE AND PRACTICAL ALTERNATIVE SOLUTION. THIS APPROACH ENVISIONS INSURERS SERVING THEIR GROUP AND INDIVIDUAL HEALTH CARE POLICY-HOLDERS ON THE SAME "SERVICE PLAN" BASIS AS THE SAME CUSTOMERS ARE NOW SERVED BY BLUE SHIELD, BLUE CROSS AND HMO-TYPE PLANS, SUCH AS KAISER. FOR EXAMPLE, AN INSURER COULD ESTABLISH (THROUGH ACQUISITION OR FORMATION OF SUBSIDIARIES) A PLAN WHEREBY ITS GROUP HEALTH COVERAGE WOULD BE PROVIDED TO INSUREDS EITHER THROUGH AN HMO OWNED BY THE INSURER, OR A STATEWIDE SERVICE PLAN OF THE INDEMNITY TYPE, SUCH AS THE "BLUES," OR BOTH. IN BOTH CASES THE DOLLARS RECEIVED WOULD BE PAID FOR "SERVICE" PLAN COVERAGE AND WOULD NOT BE SUBJECT TO THE GROSS PREMIUMS TAX.

THIS APPROACH WILL BECOME INCREASINGLY ATTRACTIVE. IT WILL PROBABLY BE USED BY INSURERS UNLESS ONE OF THE OTHER SOLUTIONS TO TAX EQUALIZATION BECOMES A REALITY.

AN IMPORTANT RESULT OF THIS LATTER "JOIN THEM IN THEIR EXEMPTION" ALTERNATIVE IS THAT THE STATE WOULD LOSE $100 MILLION DOLLARS PER YEAR IN REVENUE. BECAUSE OF THE SEVERITY OF COMPETITION, IT IS MY BELIEF THAT ONE WAY OR ANOTHER, TAX EQUALIZATION WILL OCCUR WITHIN THE NEXT FOUR YEARS.

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ASSOCIATION OF CALIFORNIA LIFE INSURANCE COMPANIES

LEWIS KELLER
PRESIDENT

1400 K STREET, SUITE 212 SACRAMENTO, CALIFORNIA 95814 (916) 442-3648

May 5, 1982

Honorable Tom Hannigan, Member
Assembly Revenue and Taxation Committee
State Capitol
Sacramento, CA 95814

Dear Tom:

This is to express the strong support of our Association for AB 3537 (Robinson).

This bill will end the unfair tax situation which our member companies currently face in providing health care coverage to California's citizens. AB 3537 does this by making the same tax applicable to all segments of the health coverage carrier industry in California.

At the present time an individual, or a group, seeking health benefit coverage has a choice between two basic kinds of plan.

First, is the "service" plan which provides medical and hospital services for a fixed periodic charge. The dollars paid to the service plan are not taxed by the State of California.

Second, is the "insured" plan under which a similar fixed periodic charge is paid. The payor is then reimbursed after receiving and paying for medical and hospital services. The dollars paid to the insured plan are, however, subject to the state gross permiums tax of 2.35%.

This differential tax treatment of essentially the same service is both illogical and unfair. All competitors selling the same product in the same marketplace should receive the same tax treatment. The current situation is tantamount to paying state sales tax on a Ford but not a Chevrolet - or gas tax on Shell but not on Standard gasoline.

Arguments suggesting that AB 3537 would put "a tax on health care" are without merit. The same tax proposed by AB 3537 is now levied on essentially the same transaction involving health care. AB 3537 clearly does not involve a tax on health care as such. The same fallacious reasoning could be used to call the personal income tax paid by physicians a tax on health care.

The argument has also been made that to apply a gross premiums tax, as proposed by AB 3537, to "nonprofit" organizations is unprecedented and a radical departure from conventional tax policy. The fact is that over 60% of the gross premiums tax now paid to the state by life insurers is paid by "nonprofit" organizations, and this has been the situation for at least 60 years. So, the "nonprofit" arguments are also groundless.

Thus, we believe the time has arrived when all segments of the health carrier industry should bear a fair share of the State's tax burden. This can be accomplished by the enactment of AB 3537.

We urge your "aye" vote on AB 3537 (Robinson) when it is heard in the Assembly Revenue and Taxation Committee on Wednesday, May 12th!

Sincerely,

Lewis Keller

Lewis Keller

LK:tv

cc: Assemblyman Richard Robinson

bcc: Assembly Revenue and Taxation Committee Staff, HIC Group, Betty Combs, Jim Kennedy, Nancy Sullivan, and Executive Committee

Submitted in behalf of Blue Shield of California

HEALTH CARE SERVICE PLAN REGULATION by Gil Kingren

The view that there is over-lapping jurisdiction between DOI and DOC in regulating HMOs, Blue Shield, PPOs, EPOs, foundations for medical care and other like organizations results from lack of appreciation of the nature of these health-plan delivery systems and the changes health delivery is undergoing. To regulate these programs it is no longer possible to consider only the plans financial viability to meet its obligations. The public needs additional protections that only an organization with special expertise backed by specific statuatory authority can provide.

Alternate delivery plans evolved in California over the past 55 years gradually have broadened the areas which must be regulated. The first strong drive to budget health costs on a prepaid basis occurred during the great depression. Ross-Loos, a closed panel plan, was organized in 1929 to provide care directly to its members and compensate its physicians on a nonfee-for-service basis. Six years later (1935) the California Medical Association endorsed and sponsored a bill which would have established a compulsory state health insurance plan. It was not enacted.

The shortage of doctors and hospitals during the war years led Henry Kaiser to enlarge his health plan for his war workers. This plan, as in the case of Ross-Loos, was a closed panel with its own hospitals. Today the Kaiser Health Plan, with more than 4.5 million members, is the largest nongovernmental direct service health plan in the world.

Through the 1930s and 1940s the American Medical Association strongly opposed all health plans not operated by physicians and insisted reimbursements be made to the patient rather than to the doctor. This position maintained doctor control by permitting the physician to set his fees and required the patient to pay the difference between the doctor's fee and the health plan reimbursement.

In the face of this firm policy by the A.M.A., the California Medical Association in 1939 established the California Physicians Service (CPS). This was revolution. Physician members agreed to accept as payment in full CPS fees from anyone earning less than $3,000 per year (about 90% of the California work force at that time.) The fees were paid directly to the member physician so that the patient had no out of pocket expense. If there were insufficient funds to pay the physicians, every fee was scaled down commensurate with the CPS cash shortage. (This actually occurred on two occasions.) CPS, which became Blue Shield, established a medical policy committee to evaluate medical practice. It removes out-moded procedures from reimbursement and incorporates new, efficacious treatments such as certain organ transplants. This is done as a public service and broadly recognized and monitored throughout the state. If a member physician, in disregard for the medical policy determination that a certain procedure is out-moded, performs that procedure on a Blue Shield member, Blue Shield will not pay the physician and holds the patient harmless of any expense. Further, if a member physician charges a Blue Shield member more than is allowed by Blue Shield, the plan refuses the additional payment and holds the member harmless for the additional payment. Additionally Blue Shield assists National government with its health programs by performing fiscal intermediary services on a cost or no-profit basis. It has also assisted the State of California in this way.

Guaranteed service, assurance of quality care and restricted service to certain providers create relationships with and responsibilities to the public that are different from insurance companies. Now that we have reviewed the genesis of some alternate delivery health plans let us examine the resultant changes.required in

the regulatory system necessary to protect the public against abuse. Some new areas of protection are: (1) Assure that doctors and hospitals are near by so they can be used; (2) Assure the member is informed on plan benefits and how to use them; (3) Assist the member to find the best health care at the lowest available price i.e., quality assurance and cost containment; (4) Promote the interests of members through interaction with providers' representative meetings, councils and grievence committees, and (5) Promote delivery of services in such a manner as to provide continuity of care.

To insurance regulators and insurance companies these were all new concepts and remain so even today. No attempt to assist the public in these crucial areas is undertaken by the DOI and the insurance code contains no such regulatory mandates. I wonder what the Department would do if the code did have such mandates.

The Knox-Keen Act, enacted in 1975 in response to the prepaid health plan scandals, regulates all of the above mentioned regulatory needs and places the authority in the DOC. The administration of the Act has been spotty as you might expect in regulating a new business requiring new expertise and techniques. Currently the Corporation Commissioner is solving the problem by establishing a health-plan regulatory section within the department with the necessary skills to do the job.

We know of no regulatory steps being taken by the DOI that recognize the unique organization of health-care service plans and the need for a new regulatory approach to protect the public from abuse.

Summary

Clearly Knox-Keene is a forward-looking Act with protections for the public. The health-care service plans of today can live under this regulation. Knox-Keene, administered by the DOC, provides the only real regulation that fits today's sophisticated plans and clearlyit is in the public interest for plans regulated by this Act to remain in DOC. In this context clearly there is no overlapping of regulatory jurisdiction between DOI and DOC.

KAISER FOUNDATION
HEALTH PLAN, INC.

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EXECUTIVE OFFICES, ORDWAY BUILDING

November 5, 1984

The Honorable Alister McAlister
Room 3112
State Capitol
Sacramento, California 95814

Dear Assemblyman McAlister:

This letter is the response of Kaiser Foundation Health Plan, Inc. to an invitation by the Assembly Finance and Insurance Committee to interested parties to comment on the subject of the overlapping jurisdiction of the Department of Corporations (DOC) and the Department of Insurance (DOI) with respect to regulation of health benefits carriers. Before addressing this question, we wish to comment on how the jurisdiction of DOC and DOI differ.

Most of the organizations subject to DOC's jurisdiction are health maintenance organizations (HMOs). DOC also has jurisdiction over all of the organizations generally referred to as service plans, such as Blue Shield and California Vision Services, except Blue Cross. HMOs differ operationally in very important ways from insurance companies. Unlike insurers, HMOs have a contractual obligation to provide or arrange direct health services for enrolled members. This requires HMOs to employ or contract for professional services, acquire, construct or lease health care facilities, and assure the availability and quality of covered health care services for their members. The payment of claims is limited to emergency services.

DOI primarily regulates insurers, many of which are in multiple lines of business, including health insurance. Unless they are operating an HMO, health insurers function as claims payers and do not have a contractual obligation to provide or arrange for health services. In addition to the many insurance companies under its jurisdiction, DOI regulates Blue Cross, a hospital service plan, and its affiliated HMOs.

The operational and legal differences between HMOs and insurers require standards and regulatory efforts which take these differences into account. The Knox-Keene Health Care Service Plan Act and its regulations, under which DOC regulates plans, is the nation's most comprehensive plan for the regulation of HMOs. DOC is required by Knox-Keene to periodically monitor access to services and quality of care. DOC has eight years of experience implementing Knox-Keene and has developed considerable expertise in regulating HMOs. Its regulations and standards have been used as a model for developing standards in other jurisdictions and have been applied by the California Legislature to the regulation of Medi-Cal prepaid health plans.

DOI does not regulate insurers or the few HMOs under its jurisdiction for access to services or quality of care. DOI and DOC regulate the carriers under their jurisdiction for minimum benefits and marketing activities. The requirements for DOI regulated carriers are less stringent and less comprehensive than those applicable to Knox-Keene plans. Both DOC and DOI regulate to protect the public against plan insolvency. DOC's requirements recognize that HMOs are primarily service organizations whose assets are predominantly in buildings and equipment rather than cash. Most of the carriers regulated by DOI are claims paying organizations whose solvency is measured on the basis of their reserves of liquid and qualified assets.

Proposals have been made in the past to transfer jurisdiction over Knox-Keene plans to DOI. We believe this would be ill-advised. It is appropriate to maintain DOC's current jurisdiction because of the operational differences between HMOs and insurers and DOC's experience in regulating HMOs. We see no advantage to the state and considerable harm to the state's regulatory efforts and to plans if a major reorganization or consolidation of the departments were to occur. The General Fund would not benefit from any consolidation or reorganization because the major regulatory activities of both departments are funded through fees or taxes on the regulated carriers. A consolidation or reorganization would be likely to disrupt current regulatory activities and would create financial and administrative burdens on the departments and on plans. While some states have consolidated regulatory activities, they do not have the history of effective regulatory activity in two departments that California has enjoyed.

There are two areas in which the jurisdiction of DOC and DOI may overlap. While most HMOs are regulated by DOC, a few, including the Blue Cross HMOs, have been placed under the jurisdiction of DOI. DOI also has jurisdiction over one service plan, Blue Cross, while the other service plans are regulated by DOC.

A second area of overlap may occur in determining which department has jurisdiction over some new types of health benefits plans. Section 740 of the Insurance Code gives DOI presumptive authority over organizations that provide health benefits coverage unless they are regulated by another agency, such as DOC. Health and Safety Code Section 1345 provides DOC with jurisdiction over plans which arrange or pay for care on a prepaid basis; however, Health and Safety Code Section 1343 excludes from DOC jurisdiction plans which are licensed by DOI unless they directly provide services through owned or contracted facilities, and hospital service plans. It may not be clear from this statutory scheme which of the two departments has jurisdiction in the case of some new "hybrid" plans which have some of the elements of an HMO.

Despite this jurisdictional ambiguity and the more stringent level of regulation under DOC, Kaiser Foundation Health Plan has been satisfied with the current arrangement for regulating health benefits carriers. However, if the Legislature wishes to clarify jurisdictional responsibility, it might wish to consider an approach which more clearly distinguishes the roles of the departments. Such an approach should recognize the operational differences between HMOs and insurers and the need for differing regulatory policies. It also should build on the expertise of DOC by retaining DOC jurisdiction over HMOs and providing for DOC jurisdiction over similar organizations.

Thank you for the opportunity to comment on this subject.

Yours truly,

KAISER FOUNDATION HEALTH PLAN, INC.

BY 
Steven R. Zatkin, Counsel

SRZ/jj
0234T

cc: Sal Bianco
Joe Criscione